Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Remand Appeal Decision:	Approved in Part	**Appeal Number:**	2204708
Remand Decision Date:	04/05/2024	**Remand Hearing Date:**	01/04/2024
Hearing Officer:	Rebecca Brochstein, BOH Deputy Director	**Record Closed:**	01/26/2024

Appearances for Appellant:

[redacted]

Appearances for MassHealth/CCM:
Michael D'Angelo, Esq., Asst. General Counsel
Demetra Kennedy, RN, CCM Clinical Manager
Linda Phillips, RN, Assoc. Director of Appeals, Regulatory Compliance & Complex Cases

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street
Quincy, MA 02171

REMAND APPEAL DECISION

Remand Appeal Decision:	Approved in Part	**Issue:**	Community Case Management (CCM); Continuous Skilled Nursing Services
Decision Date:	04/05/2024	**Hearing Date:**	01/04/2024
MassHealth's Reps.:	Michael D'Angelo Demetra Kennedy Linda Phillips	**Appellant's Reps.:**	
Hearing Location:	Board of Hearings (Videoconference)		

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapters 118E and 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated June 9, 2022, the MassHealth Community Case Management (CCM) program approved the appellant for continuous skilled nursing services (Exhibit 1). The appellant's mother filed a timely appeal on June 21, 2022, contesting the number of hours that were approved (130 CMR 610.015(B); Exhibit 2). A hearing was held on August 25, 2022, and the Board of Hearings issued a decision on November 7, 2022, approving the appeal in part and denying it in part (Exhibit A). Thereafter, the appellant's mother filed a Complaint for Judicial Review with the Superior Court pursuant to G. L. c. 30A. The court case was resolved by the parties' agreement to have the matter remanded to the Board of Hearings (Exhibit B). After multiple requests to continue, the remand hearing was held on January 4, 2024 (Exhibit C). The appeal record was held open after hearing for additional evidence and a legal brief from appellant's attorney (Exhibit F). The authorization of nursing hours is a valid basis for appeal (130 CMR 610.032).

Action Taken by MassHealth

MassHealth authorized the appellant for continuous skilled nursing services in the amount of 34

hours per week. That figure was increased to 47 hours per week pursuant to a new MassHealth evaluation and adjustments ordered in the earlier Board of Hearings decision. After considering additional evidence presented in this remand hearing, MassHealth further increased the CSN time to 52 hours per week.

Issue

The appeal issue is whether the nursing time that MassHealth authorized for the appellant is adequate or whether additional time is medically necessary.

Summary of Evidence

The record from the original appeal in 2022 sets forth the following background: The appellant, now [redacted] is enrolled in the CCM program. Her diagnoses include cerebral palsy, restrictive lung disease, seizure disorder, hypoxic brain injury, central sleep apnea/obstructive sleep apnea, oropharyngeal dysphagia, and spasticity. She has G and J tubes as well as a baclofen pump. She and her family moved from [redacted] to Massachusetts in [redacted]; shortly after the move she was hospitalized and was then admitted to a long-term care facility, where she remains to date. In June 2022, MassHealth/CCM conducted an assessment of her eligibility for continuous skilled nursing (CSN) services in anticipation of her discharge home and approved her for a total of 34 nursing hours per week. The appellant's mother appealed that determination; after a hearing, the Board of Hearings issued a written decision that approved some additional nursing time for specific tasks. The appellant's mother then filed a Complaint for Judicial Review pursuant to G. L. c. 30A. The court case was resolved with the parties' agreement to have the matter remanded to the Board of Hearings for further consideration.[1]

At the remand hearing, which was conducted by videoconference, MassHealth was represented by an EOHHS Assistant General Counsel; the CCM Clinical Manager; and the CCM Associate

[1] The Stipulation of Dismissal of the Superior Court case states in relevant part that the parties agreed to dismiss the case with prejudice, "contingent on the matter being remanded to the MassHealth Board of Hearings regarding the Plaintiff's appeal of MassHealth's dismissal of Plaintiff's appeal number 2204708 dated November 7, 2022." The Board of Hearings sought clarification from the parties, noting that the Board had conducted a hearing on the merits and issued a written decision, and had not "dismissed" the appeal. Thereafter, the MassHealth attorney responded with the following: "Specifically, both parties intend to supplement the existing record with additional evidence in the form of testimony and documentation. MassHealth intends to address [CCM's] evaluation process and procedures including a description of the so-called 'Time for Task tool', as well as explain discrepancies between the member's previously approved nursing services in [redacted] and current approval in Massachusetts as referenced by the Appellant and included in already admitted medical records. Appellant intends to address the member's medical needs, including any changes since the close of the initial hearing, as well as deficiencies in the current evaluation process and procedures and in application of the 'Time for Task tool' with respect to their failure to adequately account for the realities of home health nursing." See Exhibit B.

Director of Appeals, Regulatory Compliance, and Complex Cases. The Clinical Manager (CM) testified that she has been a nurse with CCM for many years and helps facilitate children's transitions from institutional settings to home. She stated that as part of the child's discharge plan, CCM performs an assessment for the services needed after discharge. Three months after discharge, CCM does a reevaluation to ensure the services are appropriate, note any major clinical changes, and assist the family with filling nursing hours. In the course of this reevaluation CCM may increase the hours if needed, and may also decrease hours if, for example, the reviewer determines that there is duplication with services that are provided by a school system.

The CM testified that the pre-discharge evaluation involves a head-to-toe review of systems and the clinical documentation, and that it incorporates the input of the primary caregiver as well as the primary facility nurse. The reviewer talks to the facility nurse about the necessary nursing interventions and observes some of them; she then uses the continuous skilled nursing tool guidelines to determine the time needed for each nursing intervention. The CM stated that the tool allows the reviewer flexibility to assign time that is outside the designated range.

The CM testified that she contacted the [redacted] program to establish how that state had determined the appellant was eligible for 106 nursing hours per week. She learned that the [redacted] program did not complete an in-person assessment of the appellant, and instead approved the time under a waiver that allows for consideration of the caretaker's needs. Under the waiver, the [redacted] program approved the appellant for 56 hours per week to allow for an "awake and alert caregiver" and 40 hours per week to cover the time the mother was working; she stated that the additional ten hours per week were related to the death of the appellant's father. The CM emphasized that the 106 hours that [redacted] Medicaid program approved was based on the needs of the caregiver (the mother) and not the needs of the appellant. By contrast, she stated, MassHealth – which does not have the same waiver – bases its determination solely on the member's medical needs.

The CM testified that she completed evaluations of the appellant's nursing needs on April 27 and June 1, 2022, and performed an updated assessment on May 18, 2023.[2] As in the original assessment, CCM determined the appellant has a number of clearly identifiable, specific medical needs that justify CSN services, and calculated the amount of time required to perform each nursing intervention. CCM completed a spreadsheet that reflects the nursing time allotted in each body system category, as follows:[3]

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[2] CCM also completed an assessment for personal care attendant (PCA) services, approving 25.53 day/evening hours per week (22.72 hours during school weeks), and 14 hours nighttime hours per week. See Exhibit D at 226-237.

[3] The spreadsheet as set forth here includes only those interventions that MassHealth deemed applicable to the appellant; the numerous line items on the standardized form that MassHealth marked "Not Applicable" have been omitted.

Nursing Interventions	Time	Freq.	Clinical Rationale/Medical Necessity	Total Mins Per Day
Respiratory				
Suction	0	0	Suctioning is required on an as needed basis during periods of illness. No time allotted.	0
Mechanical Ventilation Care Management (CPAP, BiPAP, Ventilator)	104	1	The administration of BiPAP via the Trilogy vent is required overnight for 12 hours per night. Time allotted to apply lubricant to the nasal area, initially apply and secure the nasal mask and assess for leaks is 10 minutes a day. The Bipap mask is repositioned 3 times per night. Desaturations do occur when the mask is dislodged but resolve when the mask is replaced with no additional intervention. Time allotted to reapply and resecure the Bipap mask including assessment is 5 minutes per episode or 15 minutes a day. Condensation is drained from the circuits 2 times per night. Time allotted is 3 minutes per episode or 6 minutes a day. Time allotted for management of the vent to include assessment of the settings, assessment of Bipap tolerance, additional assessment and management of the circuits and responding to all alarms is 5 minutes per hour or 60 minutes a day. Time allotted for ventilator maintenance including humidifier maintenance, maintenance of Oxygen (O2) equipment, emptying water traps is 10 minutes a day. Time allotted to change the circuits and water trap weekly is 10 minutes per episode (divided by 7 days) is 2 minutes a day rounded. Time allotted to change the filters monthly is 20 minutes (divided by 30 days) is 1 minute a day rounded. Total time allotted in this section is 104 minutes a day including assessment.	104
O2 Desaturations	5	6	Use of the pulse oximeter is required continuously. Time allotted to rotate and secure the wrap probe, obtain an accurate reading and assess the site is 5 minutes 6 times a day. Increased time allotted for resistance to care. Desaturations occur overnight when the Bipap mask is dislodged and resolve when the Bipap mask is repositioned. Time allotted for management of the Bipap mask in *Mechanical Ventilation Care Management*.	30
Oxygen	0	0	Oxygen (O2) is ordered for as needed use. Time allotted to assess O2 equipment for property delivery and function allotted in *Mechanical Ventilation Care Management*.	0
Skilled Assessment	0	0	Time allotted with skilled interventions.	0
Cardiac/Autonomic Instability				

Skilled Assessment	0	0	Time for cardiac assessment including the assessment of vital signs allotted with general assessment in *Skilled Assessment Needs Related to Fluctuation in Medical Status*	0

Gastro-Intestinal (GI) Nutrition				
G/J Tube Care	5	2	Care and assessment of the separate G tube and J tube sites is required for each site. There are currently no issues at either site. Time allotted is 5 minutes per episode (times 2 sites) and includes time for weekly assessment of the G tube balloon and time to change the G tube every 3 months.	10
G/J Tube Feedings	123	1	Six (6) J tube bolus feedings a day of Alphamino [sic] JR are administered on the enteral pump. Time allotted for feeding initiation and initial assessment of feeding tolerance is 10 minutes per feeding or 60 minutes a day including flushing the J tube before and after each feeding. Five (5) dose[s] of medication are administered via the G tube and 16 doses of medication a day are administered via the J tube for a total of 21 doses of medication a day. Time allotted is 3 minutes per dosage or 63 minutes a day to include time for flushing the G and J tube before and after each dose. Total time allotted is 123 minutes a day including assessment.	123
Adjustments and Venting	1	12	The G tube is attached to a Farrell bag for continuous venting. Time allotted for management, assessment of the Farrell bag (including time to change to Farrell bag every 2 days) is 1 minute every hour times 12 hours (12 times a day)	12
Intake and Output	0	0	Time allotted with general assessment in *Skilled Assessment Needs Related to Fluctuation in Medical Status.*	0
Skilled Assessment	5	3	Time allotted for GI/abdominal assessment including measurement of abdominal girth is 5 minutes 3 times a day. Additional time for assessment allotted with general assessment in *Skilled Assessment Needs Related to Fluctuation in Medical Status.*	15
Genito-Urinary (GU)				
Skilled assessment	0	0	Time allotted with general assessment in *Skilled Assessment Needs Related to Fluctuation in Medical Status.*	0
Wound Care/Skin				
Skilled Assessment	0	0	Time allotted with general assessment in *Skilled Assessment Needs Related to Fluctuation in Medical Status.*	0

Neurological				
Seizures frequency	0	0	Seizures are currently well controlled with medication administered via the G tube. Time allotted for medication administration in G/J tube feedings. The last witnessed seizure occurred in October 2022 and lasted 30 seconds and then self-resolved. Time allotted for assessment during seizures in *Neurological Skilled Assessment*.	0
Skilled assessment	3	6	Time allotted for assessment during seizures is 3 minutes every 4 hours or 6 times a day	18
Pain Management				
Pain management frequency:	1	1	Tylenol is administered via the G tube 5 times per month to manage signs and symptoms of pain as evidenced by crying and increased heart rate. Time allotted for the administration of Tylenol is 3 minutes per dose (times 5 doses=15 divided by 30) is 1 minute a day rounded. Time for pain assessment allotted in *Pain Management Skilled Assessment*.	1
Skilled Assessment	0	0	Time allotted with general assessment in *Skilled Assessment Needs Related to Fluctuation in Medical Status*.	0
Musculoskeletal				
Skilled Assessment	0	0	Time allotted with general assessment in *Skilled Assessment Needs Related to Fluctuation in Medical Status*.	0
Other considerations in skilled care needs				
Skilled Assessment Needs Related to Fluctuations in Medical Status	31	1	Time allotted for head-to-toe general assessment to include time for cardiac assessment/assessment of vital signs, additional GI, intake and output, GU, skin including time to apply protective Allevyn dressing to coccyx and Baclofen pump site, pain, additional neurological and musculoskeletal assessment during initial 12-week transition to home is 5 minutes every 4 hours or 6 times per day or 30 minutes a day. Additional assessment time allotted with skilled interventions. Time allotted to fill the Baclofen pump every 3 months is 30 minutes per episode (divided by 90 days) is [1] minute per day rounded. Total time allotted is 31 minutes a day including assessment.	31
Total Minutes Per Day				**344**
Total Hours Per Week				**40.13**

Exhibit D at 221-225.

The CCM Clinical Manager indicated that CCM then added the 6.4 hours that were approved in the November 2022 Board of Hearings decision, to arrive at a rounded-up total of 47 hours per week.

The appellant was represented at hearing by her mother, two attorneys, and two expert witnesses. The attorney noted that the appellant has been institutionalized since the family's move to Massachusetts in 2022. He asserted that there is no way for the mother to keep the appellant safe without significant (150 or more) nursing hours per week, as she requires round-the-clock care and is at risk of injury or death if a nurse is unavailable.[4]

The mother testified that when the family lived in [redacted] the appellant had 106 total daytime and nighttime nursing hours, and also received 1:1 nursing through the public school system. She stated that when a nurse was not available, she (also a registered nurse) took care of the appellant herself.

The mother testified that the appellant's feedings were previously administered through a G tube but were changed to her J tube because of poor tolerance. Even with the J tube feedings, the mother testified, the appellant still has issues with aspiration of saliva, inconsistent swallowing, and reflux. She emphasized that the appellant is not able to turn her head to clear her airway and is therefore at risk of aspiration pneumonia or choking on her secretions. She noted that feedings are administered "at a very slow rate" to promote feeding tolerance; she is very sensitive to the formula's concentration and has only been able to tolerate feeds at 56 mL/hour. The mother added that the tubes are held in place by balloons and are not permanent, and are thus susceptible to being pulled out; when this happens, a nurse must reinsert the tube before the opening closes.

The mother also testified that a nurse is needed to address the appellant's pain, as she is not able to verbalize or otherwise indicate what is wrong. When the appellant cries, the mother stated, a nurse needs to complete a head-to-toe assessment to determine the source of the pain. She stated that this can be due to any number of problems, including discomfort from her orthotics, gas, constipation, clonus, a "nasty" diaper, difficulty breathing, seizures, spasticity, or from biting down on her fingers or upper lip.

The mother stated that she works 35 hours per week and also has to care for her son, the appellant's twin brother, who has autism and developmental delays. She stated that she has no one to help her with childcare and that it is exhausting for her to care for both children at the same

[4] The appellant's hearing submission includes discharge summaries for three hospitalizations at [redacted] a variety of reports (sleep study, EEG report, gastroenterology consult, and orthopedic consult); notes from [redacted] a letter from the appellant's former physician in [redacted] and a "Chart Illustrating Frequency of Skilled Nursing Tasks Interventions." See Exhibit E.

time if there is no nurse in the home; in those cases, she feels that she can do no more than take care of the children's "bare necessities." When there is no nurse at night, the mother added, she must stay up all night to care for the appellant, which causes her to miss work the following day.

The appellant's mother testified that she is concerned that if there is insufficient nursing support the appellant will aspirate or suffocate because she is unable to "rescue" herself. She stated that the biggest issue in the overnight hours is that the appellant is unable to keep her airway clear. The mother stated that she is also worried that she will sleep through the alarms that are meant to alert her to a problem during the night.

As part of her hearing packet, the appellant submitted a letter from [redacted], a primary care physician who was on appellant's provider team in [redacted] It states as follows:

> I oversaw [appellant's] care from 2019 (when I assumed care from a colleague[]) until her move to Massachusetts in [redacted] [Appellant] was enrolled in the [redacted] Program, through which I worked in concert with a team of providers to provide [appellant] with the care she needed to reside at home with her family. The team that followed her included a primary care physician (myself), a neurodevelopmental pediatrician, a neurologist, a gastroenterology nurse practitioner, a physiatrist, and an orthopedic surgeon. During the time period I treated [appellant], her home care required the presence of an awake and alert skilled nurse at all times. The Waiver Program paid for 106 hours of skilled nursing per week and [appellant's] school paid for skilled nursing during the school day. [Appellant's mother], who is a registered nurse herself, cared for [appellant] for the remaining hours of each week. In approving 106 hours of skilled nursing per week, the Waiver Program took into consideration what was 'required to allow unpaid caregiver sleep,' and what would support [the mother's] work schedule.
>
> The complexity of [the appellant's] conditions and her medical fragility demanded multiple systems assessments with a focus on respiratory, gastrointestinal, and neurological systems. These assessments, which were performed by skilled nurses, could not be aggregated into a single block of time but rather had to be performed at various points throughout the day. The assessments were especially important for protecting [appellant's] health because she is non-verbal and could not adequately communicate any pain, discomfort, or other symptoms which she might be experiencing. Furthermore, [she] was at risk of certain medical emergencies that required the response of a skilled nurse. The potential emergencies included seizures lasting longer than five minutes, baclofen pump malfunctions, and jejunostomy feeding tube malfunctions. Skilled nursing was also necessary to attend to [her] high risk for aspiration, which required oral/nasal suctioning on an as needed [basis].
>
> In my professional opinion, 24/7 skilled nursing care was medically necessary for [appellant] because less skilled professionals would not have had the training to adequately perform assessments or identify or implement appropriate responses based

> on the results of those assessments. 24/7 skilled nursing care was also medically necessary because of the potential emergencies noted above. For example, a home health [aide] might have been able to identify that [she] was experiencing a seizure but would not have possessed the training to know when to administer medication or at what dosage.
>
> While the assessments and other services skilled nurses provided did not necessarily fill every minute of a 24-hour timespan, they comprised a multitude of tasks some of which occurred at a high frequency. Many of these tasks were completed at set intervals, such as scheduled jejunostomy tube feedings, while others were performed 'as needed,' based on [appellant's] fluctuating medical condition as assessed by the skilled nurses who attended to her. In other words, these services could not have been condensed into several continuous hours each day. (Exhibit E at 431-32)

The appellant's first expert witness, [redacted], is a registered nurse from the home health care agency Family Lives. She stated that based on her assessment of the appellant and review of the records, she believes that the appellant needs a minimum of 150 hours of nursing services per week. She emphasized that addressing the appellant's needs is significantly harder due to her inability to communicate, and that if something goes wrong a nurse is needed immediately. She maintained that due to the appellant's inability to communicate, she really needs a nurse on hand for 168 hours per week (24 hours a day).

[redacted] testified that a nurse is needed on hand for a number of reasons. She stated that the appellant suffers seizures, for which she is prescribed regular medications as well as a breakthrough medication. She testified that a nurse is needed to assess whether the appellant needs the breakthrough drug because a layperson (like a PCA) would not be able to read the signs of whether she is experiencing a seizure and when to give or to withhold the medication. In addition, she stated that a nurse is needed to assess the appellant for adverse effects and to use an Ambu bag when necessary to help her breathe. [redacted] added that a PCA is not able to administer the appellant's G and J tube medications, which she receives six or seven times per day (in addition to those that are given on an as-needed basis, which require a nursing assessment both before and after administration).

[redacted] further testified that a PCA would be unable to care for the appellant if she needs BiPAP during her J tube feeds, as this significantly elevates the risk of aspiration. She testified that the appellant is on BiPAP while on a feeding approximately nine hours per day; her feedings are administered for three hours at a time, with an hour off in between. [redacted] stated that the 30 minutes per day (once per hour) that MassHealth allowed for assessment in this area is "very, very low" and does not allow for the appellant to be cared for safely. She testified that if something goes wrong the appellant will need an immediate intervention, noting that even if the appellant seems fine during a scheduled assessment something could go wrong and require an intervention five minutes later. She stated that the appellant can exhibit subtle symptoms, such as a change in her breathing pattern, that must be caught early.

[redacted] testified that the appellant also requires continuous skilled nursing while her tube feed is infusing because she has episodes of reflux. She noted that these episodes are inconsistent, but that "it is not if [this will happen], but when." She added that the appellant has a history of hospitalization for dehydration and that she is at risk for both over- and under-nutrition. She stated that if a feed is held the appellant could get dehydrated, and if the feed is given when it shouldn't be the appellant will vomit and be at risk for aspiration. She testified that there is a lot of assessment that goes into determining whether the feed should be held or not— the nurse needs to determine what is going on with the appellant, what is causing it, and what to do about it. She stated that even if this does not happen every day or every week, skilled nursing is still needed because at some point the feeds *will* need to be held, and there is a risk of injury or death if it happens when a nurse is not present to make that determination.

Additionally, [redacted] testified, a nurse is needed to evaluate and intervene when the appellant experiences pain. She emphasized that the appellant can cry to convey her pain but is unable to communicate the reason. She stated that the nurse must assess the cause of the pain, which could be any number of things, and to determine the proper intervention. She also testified that a PCA is unable to safely complete the appellant's range of motion exercises because of her osteopenia, which increases the risk of fracture if it is done incorrectly. A nurse is also needed to manage areas of skin breakdown, particularly around the appellant's tube sites, noting that because the appellant cannot move independently it does not take a long time for a small problem to turn into a larger one.

[redacted] contended that the time-for-task tool can be accurate for predictable events, but that it does not include any consideration for the randomness or unpredictability of certain needs. For example, she stated, if the appellant is aspirating the intervention must be immediate; it is not sufficient to wait for the next nursing shift. She emphasized that it can take only five minutes for the appellant to become hypoxic and suffer irreparable damage or death.[5]

[redacted] also testified to the practicalities of finding nurses to cover shifts. She stated that the typical nursing shift is eight hours long, and it is virtually impossible to schedule a nurse to come for just a few hours at a time. She testified that in the last 25 years, she has never been successful in helping a family find a nurse to cover a few hours for a child before or after school. She further pointed out that if the family used a nurse for an eight-hour shift it would leave the other sixteen hours of the day uncovered.

The appellant's second expert witness, [redacted], is also a nursing consultant. She testified that the most acute issue for the appellant is ensuring her airway is clear. She testified that the appellant has a number of issues that can affect her breathing, including central apnea, frequent vomiting, hypotonia of her head, and oral secretions. She stated that a patient using BiPAP must be monitored carefully for desaturation, dislodgement of the mask and tubes, abdominal distension, and other complications. If the appellant does vomit and then aspirate, it is necessary

[5] The appellant submitted records from the facility where she resides as well as from her school to show the nature and frequency of skilled nursing interventions. See Exhibit E at 157-403.

to immediately reposition and suction her. She stated that most patients on BiPAP do not need constant monitoring, but given the appellant is unable to communicate her needs or distress, she does require this level of attention. She noted that the appellant's seizure activity is fairly well-controlled but added that this can change as she enters puberty.

[redacted] echoed [redacted] contention that the appellant has a significant risk of injury or death and that it is a question of when, not if, something serious will go wrong. She likened the appellant's condition to a "time bomb" that could go off at any time. She testified that the appellant's situation is "at the top of the complexity scale," as nearly all her body's systems are involved. She expressed concern about the mother suffering from fatigue if she is responsible for managing the appellant's skilled needs for hours at a time, particularly given her job and the needs of her other child. She testified that under these circumstances, the mother would be only able to safely provide nursing care for the appellant for two or three hours per day.

[redacted] stated that based on her review of the records and conversations with the appellant's nurse in [redacted] she believes the appellant should have 150 nursing hours per week. She contended that MassHealth's assessment does not account for the need for "constant vigilance" by a skilled nurse; she pointed out that the need for a particular nursing task may arise when there is no nurse on duty.

In response to the testimony of the appellant's representatives, the CCM Clinical Manager testified that the information gathered for the May 13 evaluation did not reflect that the appellant was getting continuous feeds and did not indicate she was on BiPAP during the feeds. She stated that CCM would review its determination on this task considering this updated information. As to the J tube feeds, the CCM representative stated that the evaluation indicated the appellant has been tolerating her feeds well with use of the Farrell bag. She testified that it is not common for a patient to aspirate when a feed is administered via the J tube; rather, she stated, the aspiration risk is from secretions. She also testified that there were no skin issues reported at the time of the review, and that when she met with the appellant she observed her to be smiling and happy.

The CCM Clinical Manager emphasized that the purpose of CSN hours is to support, but not replace, the primary caregiver. She pointed out that if there are not nurses to cover all shifts or if a nurse calls out the primary caregiver is responsible for taking care of those tasks. She testified that the CSN time is for hands-on tasks and pointed out that some of the tasks (like initiating/discontinuing a feed and doing an assessment) are done concurrently. She also noted that time was allotted daily for some tasks that do not necessarily occur every day, allowing for the additional time to be redistributed elsewhere.

The record was held open after hearing for the appellant's representatives to submit their own version of the time-for-task grid, for CCM to review its determination based on updated records, and for the appellant to file a response and a legal brief.[6] On January 12, 2024, the appellant

[6] The legal arguments contained in the attorney's brief are set forth in the Analysis and Conclusions of Law section below.

submitted the following grid from expert witness [redacted]:

Task	Times/week	Minutes	Total Time
Vital sign assessment with temperature. (One minute for heart rate, one minute for respiratory rate, one minute for pulse oximeter and 3-5 minutes for temperature.) Should not be done during a feeding.	3	8	24
Neurological assessment including Glasgow Coma Scale	6	5	30
Pulmonary assessment includes an assessment of breath sounds, work of breathing, breathing pattern, depth and should be completed prior to placing the Bipap, after the Bipap is in place, and any time the Bipap alarms to ensure that the alarm is not associated with a change in patient condition.	6	6	36
BiPap: Aerophagia, or swallowing air, is one potential side effect of continuous positive airway pressure (CPAP) therapy. While some amount of aerophagia is normal, the stream of air that flows into the upper airway from a CPAP device can lead to a bothersome buildup of gas in the stomach and intestines. Gastric distension, a consequence of aerophagia, can increase gastroesophageal reflux (GER) by increasing transient lower esophageal sphincter relaxations, the most common cause of reflux. Patients with documented GERD should be assessed continually while on BiPap. [Appellant] is not able to communicate when her GERD is worsening thus a person must be present to evaluate her for the issue.	9	60	540
Desaturations: Require aa nursing assessment to determine the cause and treatment for the desaturation. For example the need for oxygen to be added, (she is ordered for up to 6 LPM), or perhaps repositioning of the mask is required.	5	6	30
Cardiac assessment: Cap refill, pulses, etc.	3	5	15
Nutritional assessment (To review the current feeding regime and compare it to her weight loss or gain) Once a week for 15 minutes. Can be done while feeds are running.)	1	2.143	2.143
GU assessment including bowel sounds and abdominal girth. Should not be done while feeds are running as when a person is eating bowel sounds change.	3	10	30
JT feeds not occurring with BiPap. She has a history of reflux dnd her EEG exam on May 25, 2022 stated "The events of abrubt grimacing, puckering/pouting, crying and irritability do not have an ictal EEG correlate - and on video suggest possible reflux." In a study conducted by H C Lien 1, C S Chang, H Z Yeh, S K Poon, S S Yang, G H Chen and found in the NIH library National Library of Medicine their study concluded "that jejunal nutrient infusion without gastric distention can induce GER in both patients with reflux esophagitis and controls. This implies that GER induced by jejununal nutrients may in part explain the incapability of jejunal tube feeding to prevent gastropulmonary aspiration in patients at risk." Based upon her history, she should be constantly assessed for reflux when receiving Jtube feeds to ensure that she does not have	9	60	540

worsened reflux that might require suctioning by a nurse. Thus a nurse should be present when the tube feed is infusing.			
Flushing of j tube after feeds. See above.	6	3	18
GT placement prior to administering medications, A gastrostomy tube must be assessed for placement, to ensure that it has not migrated prior to its use.	3	3	9
Integumentary assessment (including Braden scale) (all areas except G and J Tubes) In additon to her physical mobility issues, this patient has numerous splints and other appliance that she uses throughout the day. Careful assessment of her skin and early detection of any potential issues is of the utmost importance and should be done by a nurse. Some treatments that might be ordered could be completed by unskilled personnell however the assessment should be done at least 2 times daily by a licensed nurse.	3	9	27
GT care and assessment (must wash hands and set up separately so as not to cross contaminate)	2	8	16
JT care and assessment (must wash hands and set up separately so as not to cross contaminate)	2	8	16
Farrell bag	3	4	12
Passive ROM: The patient has a dislocated hip. PROM should be provided by a nurse or other licensed professional. Should not be done during feed. Increased risk of aspiration given her GERD diagnosis.	2	15	30
Medication administration GT (can be prepared while JT feed is running but are nursing 3/3)	3	3	9
Medication administration JT (can be prepared while JT feed is running but are nursing 20/3)	20	3	60
Pain Mgmt	1	1	1
MH assessment time[7]			
Minutes per day			1445.143
Hours per day			24.08571667
Hours per week			168.6000167

See Exhibit F (with typographical errors in original).

The appellant also submitted a copy of an email from a nurse at the facility where she lives, confirming that since her admission she has received six bolus feedings per day, each lasting three hours, with an hour break in between. The feedings are initiated at 12:00 am, 4:00 am, 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm. See Exhibit F.

After reviewing the new information, CCM reported it had amended its determinations for the following categories:

Respiratory				
Skilled Assessment	45	1	Time allotted for skilled respiratory assessment is	45

[7] This line was left blank.

			45 minutes a day (per BOH decision on 11/7/2022 of Appeal Number 2204708)	

Gastro-Intestinal (GI) Nutrition				
Skilled Assessment	5	6	Time allotted increased from 15 minutes a day to 30 minutes a day	30

Pain Management				
Skilled Assessment	10	1	Time allotted for pain assessment is 10 minutes a day (Per BOH decision on 11/7/2022 of Appeal Number 2204708)	10

Other considerations in skilled care needs				
Skilled Assessment Needs Related to Fluctuations in Medical Status	61	1	Time for general assessment increased from 30 minutes a day to 60 minutes a day. Total time allotted is now 61 minutes a day.	61

With these revisions, MassHealth's authorization of nursing hours increased to 444 minutes per day, or 51.80 (rounded up to 52) hours per week. See Exhibit F.

Findings of Fact

Based on a preponderance of the evidence, I find the following:

1. The appellant is a child who is a member of MassHealth's Community Case Management (CCM) program.

2. The appellant has diagnoses that include cerebral palsy, quadriplegia, restrictive lung disease, seizure disorder, hypoxic brain injury, central sleep apnea/obstructive sleep apnea, oropharyngeal dysphagia, constipation, scoliosis, and spasticity. She uses a J tube for feeding and medications, and has a G tube for venting and medications. She also has a baclofen pump.

3. The appellant is nonverbal and communicates via eye gaze and with a communication board. She has no head or neck control and cannot sit up without assistance.

4. In [redacted], the appellant and her family relocated to Massachusetts from [redacted] where the Medicaid program had authorized her for a block period of up to 106 hours of nursing services per week pursuant to a waiver program.

5. Shortly after the move, the appellant was hospitalized for dehydration and was then admitted to a long-term care facility, where she has remained to date.

6. The appellant's mother works full-time as a nurse. Her twin brother, who lives at home, has autism and developmental delays. The appellant's father is deceased.

7. In June 2022, MassHealth/CCM evaluated the appellant for continuous skilled nursing (CSN) services and approved her for 34 nursing hours per week. The appellant filed a timely appeal.

8. After a hearing, the Board of Hearings approved the appeal in part, increasing the nursing hours by 385 minutes (about 6.4 hours) per week.

9. Thereafter, the appellant filed a Complaint for Judicial Review with the Superior Court pursuant to G. L. c. 30A.

10. In May 2023, while the Superior Court case was pending, MassHealth/CCM conducted another assessment of the appellant's need for CSN hours as well as an evaluation for personal care attendant (PCA) services.

    a. CCM approved the appellant for 40.13 CSN hours per week. CCM added the 6.4 hours that the Board of Hearings had approved in the November 2022 decision to arrive at a total of 46.53 (rounded up to 47) CSN hours per week.

    b. CCM approved PCA services in the amount of 25.13 day/evening hours (22.72 hours during school weeks) plus 14 nighttime hours.

11. In August 2023, the Superior Court case was resolved by the parties' agreement to have the matter remanded to the Board of Hearings for further consideration.

12. On January 4, 2024, the Board of Hearings convened a remand hearing.

13. After considering testimony at hearing, MassHealth revised its determination to approve 51.80 (rounded up to 52) CSN hours per week.

14. MassHealth/CCM determines a member's nursing needs using a time-for-task approach. This involves identifying specific skilled nursing interventions needed for each body system, calculating the amount of time required to perform each intervention, and adding them together to get a total weekly figure.

15. The appellant's most acute medical issue is maintaining a clear airway. She is unable to reposition herself or take other measures to clear her own airway.

    a. The appellant has a number of issues that can affect her breathing, including central apnea, frequent vomiting, hypotonia, and oral secretions.

    b. The appellant is prone to aspirating her secretions, putting her at risk of aspiration

pneumonia or choking. When she aspirates it is necessary to immediately reposition and suction her.

c. The appellant uses a BiPAP machine to assist with her breathing. Use of the machine requires careful monitoring for desaturation, dislodgement of the mask and tubes, abdominal distension, and other complications.

d. The appellant was hospitalized for abdominal distention and emesis in January 2023, and for oxygen desaturation and possible bowel obstruction in October 2023.

e. The appellant is on BiPAP during feedings approximately nine hours per day. This significantly elevates the risk of aspiration.

f. The appellant may exhibit only subtle changes, such a change in her breathing pattern, when she has a respiratory issue that needs to be addressed. A skilled nurse is needed to make this assessment.

16. The appellant is given six bolus feedings per day through her J tube.

    a. To promote feeding tolerance, the appellant is fed at a slow rate; each feed is administered over three hours, with an hour break in between. The feedings are initiated at 12:00 am, 4:00 am, 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm.

    b. The appellant's feeding tubes are held in place by balloons and are not permanent, making them susceptible to being pulled out.

    c. The appellant is prone to dehydration if a feeding is held and is prone to vomiting and possible aspiration if a feeding is administered when it should not be. A nurse is needed to determine when and if to hold a feeding. On at least one recent occasion a feeding was paused for 30 minutes to address an episode of coughing and emesis.

17. The appellant has a history of seizures. Though the seizures have been fairly well-managed with regular medications, she still has some breakthrough episodes that require additional medication. A nurse is needed to assess the appellant's seizure activity as well as her response to the medication.

18. The appellant requires frequent interventions for pain management, as she can cry to convey her pain but is unable to communicate about the nature or cause. A nurse is needed to assess the cause and to determine the proper intervention.

19. The appellant requires range of motion exercises for her upper and lower extremities twice per day.

a. MassHealth/CCM approved PCA time for range of motion exercises twice per day.

b. Due to the appellant's diagnosis of osteopenia, hip dislocation, and risk of fractures, range of motion exercises should be completed by a skilled nurse.

20. The appellant requires care for skin breakdown, particularly around her tube sites. A skilled nurse is needed to assess and treat the appellant for skin breakdown.

21. Certain nursing tasks are performed on a schedule, at set intervals, but others are done on an as-needed basis based on fluctuations in the appellant's medical condition.

    a. Recent notes from the appellant's school indicate regular episodes of reflux/spitting up, spasms, seizures, and blood and redness around her tube sites.

    b. Recent records from the facility where she lives show episodes of vomiting up bile, retching, spasticity, abdominal discomfort, and screaming and crying.

22. Given her full-time job and the heightened needs of her other child, the appellant's mother would be able to safely provide nursing care for the appellant for about three hours per day.

Analysis and Conclusions of Law

Complex care members are MassHealth members whose medical needs, as determined by the MassHealth agency or its designee, are such that they require a nurse visit of more than two continuous hours of nursing services to remain in the community. See 130 CMR 438.402. Pursuant to 130 CMR 438.414, the MassHealth agency or its designee provides administrative care management that includes service coordination with CSN agencies as appropriate. The purpose of care management is to ensure that a complex care member is provided with a coordinated LTSS package that meets the member's individual needs and to ensure that the MassHealth agency pays for nursing, complex care assistant services, and other community LTSS only if they are medically necessary in accordance with 130 CMR 450.204. The complex care member regulations further provide as follows:

(A) Care Management Activities.

(1) Enrollment. The MassHealth agency or its designee automatically assigns a clinical manager to members who may require a nurse visit of more than two continuous hours of nursing and informs such members of the name, telephone number, and role of the assigned clinical manager.

(2) LTSS Needs Assessment. The clinical manager performs an in-person visit with the member, to evaluate whether the member meets the criteria to be a complex care member as described in 130 CMR 438.402 and 438.410(B). If the

member is determined to meet the criteria as a complex care member, the clinical manager will complete a LTSS Needs Assessment. The LTSS Needs Assessment will include input from the member, the member's caregiver, if applicable, LTSS providers, and other treating clinicians. The LTSS Needs Assessment will identify (a) skilled and unskilled care needs within a 24-hour period; (b) current medications the member is receiving; (c) durable medical equipment currently available to the member; (d) services the member is currently receiving in the home and in the community; and (e) any other case management activities in which the member participates.

(3) Service Record. The clinical manager:

(a) develops a service record, in consultation with the member, the member's primary caregiver, and where appropriate, the CSN agency and the member's physician or ordering non-physician practitioner, that 1. lists those LTSS services that are medically necessary, covered by MassHealth, and required by the member to remain safely in the community, and to be authorized by the clinical manager; 2. describes the scope and duration of each service; 3. lists other sources of payment (e.g. TPL, Medicare, DDS, AFC); and 4. informs the member of his or her right to a hearing, as described in 130 CMR 438.414.

(b) provides the member with copies of 1. the service record, one copy of which the member or the member's primary caregiver is requested to sign and return to the clinical manager. On the copy being returned, the member or the member's primary caregiver should indicate whether he or she accepts or rejects each service as offered and that he or she has been notified of the right to appeal and provided an appeal form; and 2. the LTSS Needs Assessment.

(c) provides information to the CSN agency about services authorized in the service record that are applicable to the CSN agency.

(4) Service Authorizations. MassHealth or its designee will authorize those LTSS in the service record, including nursing and complex care assistant services, that require prior authorization and that are medically necessary, as provided in 130 CMR 438.412, and coordinate all nursing services, any applicable home health agency services, and any subsequent changes with the CSN agency, home health agency or independent nurse prior authorization, as applicable. MassHealth or its designee may also authorize other medically necessary LTSS including, but not limited to, personal care attendant (PCA) Services, therapy services, durable medical equipment (DME), oxygen and respiratory therapy equipment, and prosthetic and orthotics.

(5) Discharge Planning. The clinical manager may participate in member hospital discharge-planning meetings as necessary to ensure that medically necessary LTSS necessary to discharge the member from the hospital to the community are authorized and to identify third-party payers.

(6) Service Coordination. The clinical manager will work collaboratively with any other identified case managers assigned to the member.

(7) Clinical Manager Follow-up and Reassessment. The clinical manager will provide ongoing care management for members to (a) determine whether the member continues to meet the definition of a complex care member; and (b) reassess whether services in the service record are appropriate to meet the member's needs.

(B) CSN Agency Care Management Activities. The CSN agency must closely communicate and coordinate with the MassHealth agency's or its designee's clinical manager about the status of the member's nursing and complex care assistant needs, in addition, but not limited to, (1) The amount of authorized CSN and complex care assistant hours the agency is able and unable to fill upon agency admission, and periodically with any significant changes in availability; (2) Any recent or current hospitalizations or emergency department visits, including providing copies of discharge documents, when known; (3) Any known changes to the member's nursing needs that may affect the member's CSN needs; (4) Needed changes in the agency's CSN agency PA; and (5) Any incidents warranting an agency to submit to MassHealth or its designee an incident report. See 130 CMR 438.415(C)(2).

The MassHealth regulations governing clinical eligibility for skilled nursing services are found at 130 CMR 438.410:

(A) Clinical Criteria for Nursing Services.

(1) A nursing service is a service that must be provided by a registered nurse or a licensed practical nurse to be safe and effective, considering the inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.

(2) Some services are nursing services on the basis of complexity alone (for example, intravenous and intramuscular injections). However, in some cases, a service that is ordinarily considered unskilled may be considered a nursing service because of the patient's condition. This situation occurs when only a registered nurse or licensed practical nurse can safely and effectively provide the service.

(3) When a service can be safely and effectively performed (or self-administered)

by the average nonmedical person without the direct intervention of a registered nurse or licensed practical nurse, the service is not considered a nursing service, unless there is no one trained and able to provide it.

(4) Nursing services for the management and evaluation of a plan of care are medically necessary when only a registered nurse or licensed practical nurse can ensure that essential care is effectively promoting the member's recovery, promoting medical safety, or avoiding deterioration.

(5) Medical necessity of services is based on the condition of the patient at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period.

(6) A member's need for nursing care is based solely on his or her unique condition and individual needs, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

(B) Clinical Eligibility for CSN Services. A member is clinically eligible for MassHealth coverage of CSN services when all of the following criteria are met.

(1) There is a clearly identifiable, specific medical need for a nursing visit to provide nursing services, as described in 130 CMR 438.410(A), of more than two continuous hours;

(2) The CSN services are medically necessary to treat an illness or injury in accordance with 130 CMR 438.410; and

(3) Prior authorization is obtained by the CSN agency in accordance with 130 CMR 438.411.

The MassHealth agency pays for only those CSN services that are medically necessary. See 130 CMR 438.419(B). A service is medically necessary if:

(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and

(2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to MassHealth. Services that are less costly to MassHealth include, but are not limited to, health care reasonably known by the provider, or identified by MassHealth pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR

450.317(C), 503.007, or 517.007. (130 CMR 450.204(A))

At issue in this appeal is MassHealth's authorization of continuous skilled nursing hours for the appellant, a CCM member, in anticipation of her discharge home from a long-term facility. MassHealth's original authorization, in June 2022, was for 34 CSN hours per week. The agency has gradually increased this figure— first in response to a Board of Hearings decision in November 2022; then in a new evaluation conducted in May 2023, while that decision was under judicial review; and finally, in the record-open period that followed the remand hearing. This most recent adjustment brought MassHealth's authorization up to 52 CSN hours per week.

In each assessment, MassHealth used a "time-for-task" tool to assign time for each discrete skilled nursing intervention that the appellant requires, adding these together to arrive at the total number of skilled nursing hours per week. MassHealth suggests that this system ensures the approved time will be based solely on the medical needs of the member and not on other factors, such as the needs of the primary caregiver. The appellant takes issue with MassHealth's "unnecessarily rigid application" of the time-for-task system in the appellant's case, asserting that it "does not adequately account for the around-the-clock and unpredictable nature of [her] unique condition and individualized nursing needs." See Exhibit F. She argues that MassHealth regulations and federal law require the agency to cover all medically necessary services that she needs to remain in the community, and that CCM's time-for-task approach does not meet that standard in practice.

Considering all the evidence in the record, I am persuaded that MassHealth's methodology, as applied to this unique case, does not adequately address the full scope of the appellant's nursing needs and results in an underestimation of the nursing time she requires.[8] The appellant's representatives presented a highly detailed picture of the appellant's needs and the numerous skilled nursing interventions she requires on a regular basis. What stands out in the record – particularly in the documentation from the nursing facility and school, the expert testimony, and the letter from the appellant's former primary care provider in [redacted] – is that the appellant's nursing needs are frequent and often unpredictable. Though some nursing tasks are completed on a set schedule throughout the day and night, others are unplanned and require immediate action; for example, a nurse may be needed at any given time to clear the appellant's airway, to manage a dislodged or malfunctioning feeding tube, to administer seizure medication, or to assess and address potential sources of pain. These situations, which are exacerbated by the appellant's inability to communicate her needs, can lead to serious or even lethal harm if there is no nurse on site.

In its time-for-task approach, MassHealth seeks to quantify, minute by minute, the total time needed for each of a member's nursing interventions in a particular week. This methodology presupposes the member's needs are largely consistent and predictable. As the evidence here demonstrates, however, the appellant's nursing needs are neither consistent nor predictable,

[8] I note that the evidence offered in this case after remand is substantially more detailed and comprehensive than the record in the original hearing.

and are therefore not easily quantified. The appellant requires skilled nursing interventions, both planned and unplanned, throughout the day, and as such, her needs cannot be addressed on a part-time basis. As home care nurses largely work in 8-hour shifts, and the appellant's nursing needs arise around the clock, it would not be possible to predict and align nursing visits with each of the precise moments the appellant requires skilled interventions over the course of a 24-hour period. These scheduling limitations would effectively require the appellant to condense her MassHealth-approved hours into a single nursing shift each day, leaving her without any nursing care about two-thirds of the time. There is little doubt that such an outcome would fall far short of meeting the appellant's needs.

As set forth above, MassHealth evaluates the medical necessity of nursing services "based solely on [the member's] unique condition and individual needs." 130 CMR 438.410(A)(6). The appellant argues that based on her specific needs, she requires a minimum of 150 hours per week of nursing services (and up to 168 hours, or 24 hours per day) to be safely maintained in the community. For the reasons discussed above, she has made a convincing case that she requires nursing services in this range. The record indicates, however, that the appellant's mother is able to support the appellant's nursing needs on her own for up to three hours per day (21 hours per week); this figure must therefore be deducted from the weekly total, leaving 147 hours per week for which coverage is needed. Additionally, the total will need to be adjusted to account for any nursing hours provided by the appellant's local school system once she has been enrolled. The appellant will be authorized for 147 hours per week for a period of three months from the date of her discharge, at which point MassHealth will reassess accordingly.

This appeal is approved in part.

Order for MassHealth

Approve the appellant for 147 CSN hours per week for a period of three months from the date of her discharge home.

Implementation of this Decision

If this decision is not implemented within 30 days after the date of this decision, you should contact MassHealth. If you experience problems with the implementation of this decision, you should report this in writing to the Director of the Board of Hearings at the address on the first page of this decision.

Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to Court in accordance with Chapter 30A of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your

receipt of this decision.

Rebecca Brochstein
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Board of Hearings

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