Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2206737
Decision Date:	12/1/2022	**Hearing Date:**	10/04/2022
Hearing Officer:	Scott Bernard		

Appearance for Appellant:

[redacted]

Appearance for MassHealth/Aging Services Access Point (ASAP):
Thelma Towne, RN (Elder Services of Berkshire County) *via* telephone

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

APPEAL DECISION

Appeal Decision:	Denied	**Issue:**	Long Term Care Services Screening
Decision Date:	12/1/2022	**Hearing Date:**	10/04/2022
MassHealth/ASAP Rep.:	Thelma Towne, RN	**Appellant's Rep.:**	[redacted]
Hearing Location:	Quincy Harbor South		

Authority

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

Jurisdiction

Through a notice dated August 10, 2022, Elder Services of Berkshire County Aging Services Access Point (the ASAP) determined that the appellant was not clinically eligible for MassHealth payment of nursing-facility services, because those services were not medically necessary, his medical needs could be met in the community, and there were services available in the community. (See 130 CMR 456.409; 456.408(B), and Exhibit (Ex.) 1, pp. 3-4). An appeal of this notice was filed in a timely manner on September 7, 2022. (See 130 CMR 610.015(B) and Ex. 1, p. 1). Individual MassHealth agency determinations regarding scope and amount of assistance (including, but not limited to, level-of-care determinations) are valid grounds for appeal. (See 130 CMR 610.032).

Action Taken by MassHealth/ASAP

The ASAP determined that appellant was not clinically eligible for MassHealth coverage of nursing facility services on a long-term basis, his medical needs could be met in the community, and there were services available in the community.

Issue

The appeal issues are whether the ASAP was correct, pursuant to 130 CMR 456.409 and 456.408(A)(2) in determining that the appellant did not meet the nursing home admission criteria for nursing facility services on a long-term basis, his medical needs could be met in the community, and services were

available in the community.

Summary of Evidence

The appellant is an individual over the age of 65. (Ex. 2; See e.g. Ex. 4A, 4B, 4C). The ASAP representative testified to the following.[1] In order to be eligible for MassHealth payment for nursing facility services, an applicant must be clinically eligible for those services. (See 130 CMR 456.409; Ex. 4A, pp. 5-6). This means that the applicant requires at least one of the skilled services listed in 130 CMR 456.409(A) per day or have a medical or mental condition requiring the combination of at least three services from 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in (C). (Ex. 4A, pp. 5-6).

The ASAP representative performed a nursing facility short term review screening on August 10, 2022. During the on-site assessment, the ASAP representative reviewed the documentation and spoke to nursing facility's unit manager, the nursing facility's director of admissions, and the nursing facility's administrator.

The appellant has the following relevant diagnoses: history of malignant neoplasm of the colon; adjustment disorder with mixed anxiety and depressed mood; left above the knee amputation; history of esophagitis; hyperlipidemia; history of antineoplastic chemotherapy induced pancytopenia; history of COVID-19; and insulin dependent diabetes. The appellant was taking the following medications: Aspirin, cyclobenzaprine, Lantus insulin, lisinopril, metformin, oxycodone, pravastatin, protonix, vitamin C, and vitamin D. The ASAP representative noted that the appellant was independent with bathing, grooming, dressing, ambulation with Walker and prosthesis, wheelchair mobility, bed mobility, positioning, and eating. The ASAP representative also noted that the appellant was independent with outdoor mobility as well. The appellant required a prosthesis and walker for ambulation and was independent with managing both. The appellant was also continent of bowel and bladder. The appellant's vision was adequate with glasses, and his hearing was adequate with no aid required. His speech was clear.

The ASAP representative met with the appellant and the unit manager in the appellant's room. The appellant was lying on top of the bed and was dressed and well groomed. The ASAP representative did not note any cognitive or mood issues. The appellant stated that he was still looking for an apartment. The appellant stated he needed to go somewhere that accepted cats as he has pet cats that are currently being fostered and he wants them back. The appellant stated he looked at couple of assisted living facilities but declined these as he "needs" a place where he can have his cats.

Prior to his hospitalizations and nursing facility admission, the appellant lived in his own home, which was a duplex. The side of the duplex the appellant lived in was condemned, however, and he was unable to return there. The appellant had an initial conversion on October 27, 2021 for conversion date of October 3, 2021. The ASAP approved the appellant for 90 days. The appellant at that time was receiving chemotherapy, had a stage 3 wound, and required assistance with activities of daily living (ADLs), and medications. The ASAP made a Comprehensive Screening and Services Model (CSSM) referral at that time.

[1] See Ex. 4A, pp. 7-9.

The appellant had a short-term review on December 3, 2021 and was given a further 90 days. The appellant at that time was actively participating in therapy and continued to require assistance with ADL's, and medications and he continued to follow up with oncology. The ASAP made a Moving Forward Plan (MFP) referral at that time. The MFP may have allowed the appellant to make possible modification to the side of appellant's home that was not condemned.

The appellant had a short-term review on March 29, 2022 and was given a further 90 days as the appellant was still working with and making progress with therapy and continued to require assistance with medications and managing his diabetes. The appellant continued to work with MFP and also AdLib Center for Independent Living for housing. The CSSM referral was returned as the appellant was working with MFP and AdLib.

The appellant had a short-term review on June 24, 2022 and was given 30 days as the appellants still required assistance with medications, injections, and blood sugar checks. The appellant continued to work with MFP and also AdLib for housing.

The appellant had short-term review on July 21, 2022 and was given 30 days as the appellant was receiving medication teaching and return demonstration with managing his diabetes, blood sugar checks and insulin injections. The appellant had not yet found an apartment that would accept his cats. The appellant did visit a local an ALF (Rosewood Manor) on the day of the in-person visit for this assessment.

The appellant had a short-term review done on August 10, 2022 and was issued a denial with last coverage day of August 21, 2022. The appellant at that time was independent with ADL's, medications, and managing diabetes. The ASAP RN's determination was to deny the request for services dated August 10, 2022. Documentation could not be found to support the need for continued nursing facility stay. The appellant's needs could be met in the community. The ASAP would continue to track appellant for 90 days.

The ASAP representative visited the appellant again on September 23, 2022. The appellant remained independent with all ADL's per the documentation and interview with nursing staff. The appellant continued to do his own insulin injections. The appellant had had no decline in function or medical issues since last visit. The appellant continued to have no nursing skill.

The ASAP representative testified that the appellant was not clinically eligible of further short-term assistance as he did not require skilled nursing services, as stated in 130 CMR 456.409(A), and was not receiving at least three services from 130 CMR 456.409(B) and (C) as required by the Executive Office of Elder Affairs. The appellant receives medications, which is a skill covered by 130 CMR 456.409(C) but according to the nursing staff at the facility, he has demonstrated competence in self- checking his blood sugars as well as self-administering insulin injections and other medications.

The appellant stated that he is having trouble finding a new place to live. The Massachusetts Rehabilitation Commission (MRC) representative stated the appellant has an application in with one housing authority and is appealing the denial. The MRC representative stated the appellant has been in communication with another housing authority and there is a potential for placement there. The MRC representative asserted that the appellant was still not independent with his prosthesis and relies on his

wheelchair for mobility. There is a possibility for the appellant's health to decline in the community if he is not able to live in housing that is suitably set up for him. The nursing facility administrator stated that she was impressed with the appellant's tenacity in continuing to search for a place to stay and with the MRC representative for her advocacy as well as with the ASAP representative.

Findings of Fact

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

1. The appellant is an individual over the age of 65. (Ex. 2; See e.g. Ex. 4A, 4B, 4C).

2. In order to be eligible for MassHealth payment for nursing facility services, an applicant must be clinically eligible for those services. (Ex. 4A, pp. 5-6; Testimony of the ASAP representative).

3. This means that the applicant requires at least one of the skilled services listed in 130 CMR 456.409(A) per day or have a medical or mental condition requiring the combination of at least three services from 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in (C). (Ex. 4A, pp. 5-6; Testimony of the ASAP representative).

4. The ASAP representative performed a nursing facility short term review screening on August 10, 2022. c

5. During the on-site assessment, the ASAP representative reviewed the documentation and spoke to nursing facility's unit manager, the nursing facility's director of admissions, and the nursing facility's administrator. (Ex. 4A, pp. 7-9; Testimony of the ASAP representative).

6. The appellant has the following relevant diagnoses: history of malignant neoplasm of the colon; adjustment disorder with mixed anxiety and depressed mood; left above the knee amputation; history of esophagitis; hyperlipidemia; history of antineoplastic chemotherapy induced pancytopenia; history of COVID-19; and insulin dependent diabetes. (Ex. 4A, pp. 7-9; Testimony of the ASAP representative).

7. The appellant was taking the following medications: Aspirin, cyclobenzaprine, Lantus insulin, lisinopril, metformin, oxycodone, pravastatin, protonix, vitamin C, and vitamin D. (Ex. 4A, pp. 7-9; Testimony of the ASAP representative).

8. The appellant was independent with bathing, grooming, dressing, ambulation with Walker and prosthesis, wheelchair mobility, bed mobility, positioning, and eating. (Ex. 4A, pp. 7-9; Testimony of the ASAP representative).

9. The appellant was independent with outdoor mobility as well. (Ex. 4A, pp. 7-9; Testimony of the ASAP representative).

10. The appellant required a prosthesis and walker for ambulation and was independent with managing both. (Ex. 4A, pp. 7-9; Testimony of the ASAP representative).

11. The appellant was also continent of bowel and bladder. (Ex. 4A, pp. 7-9; Testimony of the

ASAP representative).

12. The appellant's vision was adequate with glasses, his hearing was adequate with no aid required, and his speech was clear. (Ex. 4A, pp. 7-9; Testimony of the ASAP representative).

Analysis and Conclusions of Law

Under 130 CMR 456.408(A), MassHealth pays for nursing-facility services if all the following conditions are met:

> (1) MassHealth or its agent has determined that individuals aged 22 and older meet the nursing-facility services requirements of 130 CMR 456.409 or that the medical review team coordinated by the Department of Public Health has determined that individuals aged 21 or younger meet the criteria of 130 CMR 519.006(A)(4).
> (2) MassHealth or its agent has determined that community care is either not available or not appropriate to meet the individual's needs.
> (3) The requirements for preadmission screening at 130 CMR 456.410 have been met.

The service requirements for medical eligibility for nursing home services are contained in 130 CMR 456.409, which state the following:

> To be considered medically eligible for nursing-facility services, the member or applicant must require one skilled service listed in 130 CMR 456.409(A) daily or the member must have a medical or mental condition requiring a combination of at least three services from 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C).
>
> (A) Skilled Services. Skilled services must be performed by or under the supervision of a registered nurse or therapist. Skilled services consist of the following:
> (1) intravenous, intramuscular, or subcutaneous injection, or intravenous feeding;
> (2) nasogastric-tube, gastrostomy, or jejunostomy feeding;
> (3) nasopharyngeal aspiration and tracheostomy care, however, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services;
> (4) treatment and/or application of dressings when the physician has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions);
> (5) administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema);
> (6) skilled-nursing observation and evaluation of an unstable medical condition (observation must, however, be needed at frequent intervals throughout the 24 hours; for example, for arteriosclerotic heart disease with congestive heart failure);
> (7) skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure

that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery and safety;
(8) insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter (a urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled-nursing care). However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled-nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection);
(9) gait evaluation and training administered or supervised by a registered physical therapist at least five days a week for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame. The member must require these services in an institutional setting;
(10) certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical-therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record);
(11) hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications; and
(12) physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame.

(B) Assistance with Activities of Daily Living. Assistance with activities of daily living includes the following services:
(1) bathing when the member requires either direct care or attendance or constant supervision during the entire activity;
(2) dressing when the member requires either direct care or attendance or constant supervision during the entire activity;
(3) toileting, bladder or bowel, when the member is incontinent of bladder or bowel function day and night, or requires scheduled assistance or routine catheter or colostomy care;
(4) transfers when the member must be assisted or lifted to another position;
(5) mobility/ambulation when the member must be physically steadied, assisted, or guided in ambulation, or be unable to propel a wheelchair alone or appropriately and requires the assistance of another person; and
(6) eating when the member requires constant intervention, individual supervision, or direct physical assistance.

(C) Nursing Services. Nursing services, including any of the following procedures performed at least three times a week, may be counted in the determination of medical eligibility:
(1) any physician-ordered skilled service specified in 130 CMR 456.409(A);
(2) positioning while in bed or a chair as part of the written care plan;
(3) measurement of intake or output based on medical necessity;
(4) administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions;
(5) staff intervention required for selected types of behavior that are generally considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers; or requiring a consistent staff one-to-one ratio for reality orientation when it relates to a specific diagnosis or behavior as determined by a mental-health professional;
(6) physician-ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals);
(7) physician-ordered licensed registered nursing observation and/or vital-signs monitoring, specifically related to the written care plan and the need for medical or nursing intervention; and
(8) treatments involving prescription medications for uninfected postoperative or chronic conditions according to physician orders, or routine changing of dressings that require nursing care and monitoring.

The appellant has not shown by a preponderance of the evidence that he has need of nursing facility level of care at the time. There was no evidence that the appellant required any of the skilled services listed under 130 CMR 456.409(A). The appellant was also not in need of any of the nursing service listed under 130 CMR 456.409(C). The ASAP representative testified that that the appellant was independent with all the ADLs listed under 130 CMR 456.409(B). The MRC representative did assert that the appellant was still not independent with his prosthesis and relied on his wheelchair for mobility. There was no assertion that the appellant was unable to propel his wheelchair without the assistance of another. In any case, even if the record showed that the appellant required assistance for this ADL, it would not be enough to indicate the need for nursing facility services.

For the above stated reasons, the appeal is DENIED.

Order for MassHealth/ASAP

None.

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.

Scott Bernard
Hearing Officer
Board of Hearings

cc:

Desiree Kelley, RN, BSN, Massachusetts Executive Office of Elder Affairs, 1 Ashburton Pl., 5th Flr., Boston, MA 02108

[redacted]