Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2207762
Decision Date:	11/29/2022	**Hearing Date:**	11/14/2022
Hearing Officer:	Patricia Mullen		

Appearances for Appellant:
[redacted]

Appearances for SCO:
Cassandra Horne, Appeals and Grievances Operations Manager, CCA; Jeremiah Mancuso, RN, Appeals and Grievances Manager, CCA; Kaley Ann Emery, Appeals Supervisor, CCA

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:**	Adult Day Health
Decision Date:	11/29/2022	**Hearing Date:**	11/14/2022
SCO's Reps.:	Cassandra Horne, Appeals and Grievances Operations Manager, CCA; Jeremiah Mancuso, RN, Appeals and Grievances Manager, CCA; Kaley Ann Emery, Appeals Supervisor, CCA	**Appellant's Reps.:**	Pro se; daughter
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 19, 2022[1], Commonwealth Care Alliance (CCA), a MassHealth Senior Care Organization (SCO) for Medicare/Medicaid eligible members, denied the appellant's internal appeal of a denial of a request for 5 days a week of adult day health services (ADH) because CCA determined that the appellant did not meet clinical criteria for adult day health services. (Exhibit 5, p. 125, 130 CMR 404.405). The appellant filed this appeal with the Board of Hearings (BOH) in a timely manner on October 12, 2022[2]. (see 130 CMR 610.015(B) and Exhibit

[1] Exhibit 1 is a denial notice dated August 30, 2022, however that is a copy of the initial denial notice dated July 27, 2022, not the denial of the internal appeal. (Exhibit 5, p. 29).

[2] In MassHealth Eligibility Operations Memo (EOM) 20-09 dated April 7, 2020, MassHealth states the following:

2). A SCO's denial of an internal appeal of a request for prior authorization is valid grounds for appeal. (see 130 CMR 610.032).

Action Taken by SCO

CCA denied the appellant's internal appeal of a denial of a request for ADH services.

Issue

The appeal issue is whether CCA was correct, pursuant to 130 CMR 404.405; 404.406, in determining that the appellant did not meet clinical eligibility criteria for ADH services.

Summary of Evidence

The appellant appeared telephonically at the hearing with his daughter/authorized representative. CCA was represented telephonically by its Appeals and Grievances Operations Manager; its Appeals and Grievances Manager, who is also a registered nurse; and its Appeals Supervisor.

The appellant is over age 65, lives alone, and has a primary diagnosis of hypertension. (Exhibit 5, pp. 5, 12, 28). CCA's Appeals and Grievances Operations Manager testified that the appellant has been a member of CCA's Senior Care Options plan since February 1, 2020. (Exhibit 5, p. 10). The appellant's provider, Quality Life Adult Day Service, submitted a request for prior authorization for 5 days a week of ADH services to CCA on June 7, 2022. (Exhibit 5, pp. 12-14). CCA's Appeals and Grievances Manager, (hereinafter "CCA's representative") stated that the appellant was attending an adult day health program when he joined CCA in February, 2020 and the services were protected under the Covid public health emergency, with no review until the June 7, 2022 request. The CCA representative stated the appellant had a Minimum Data Set (MDS) assessment on July 21, 2022. The CCA representative noted that the MDS assessment is done bi-annually and is a review of a member's current conditions and needs. CCA's representative stated that, based on the MDS assessment, the appellant is independent with activities of daily living (ADLs) and does not require at least daily, or on a regular basis, hands-on physical assistance or cueing and supervision, throughout the entire activity, with one or more qualifying ADLs. (Exhibit 5, p. 28). The CCA representative testified that the appellant does not require any skilled care services. CCA denied the appellant's request for ADH services by notice dated July 27, 2022. (Exhibit 5, p. 29).

The appellant appealed CCA's initial denial notice on July 29, 2022. (Exhibit 5, p. 37). The appellant's representative noted in the Level I appeal that the appellant suffers from depression and

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- Regarding Fair Hearings during the COVID-19 outbreak national emergency, and through the end of month in which such national emergency period ends;
    - All appeal hearings will be telephonic; and
    - Individuals will have up to 120 days, instead of the standard 30 days, to request a fair hearing for member eligibility-related concerns.

PTSD and enjoys going to ADH where he can interact with other Spanish speaking people. (Exhibit 5, p. 37). The CCA Appeals and Grievances team, including a CCA Medical Director, reviewed the appellant's Level I appeal. (Exhibit 5, p. 124). CCA's Medical Director noted that the appellant's diagnoses include alcohol dependence in remission, hypertension, overweight, and major depressive disorder. (Exhibit 5, p. 124). CCA's Medical Director wrote that, based on documentation in the record, the appellant is independent with ADLs and most instrumental activities of daily living (IADLs) and does not evidence the need for any assistance with ADLs. (Exhibit 5, p. 124). The Medical Director denied the Level I appeal and CCA issued the final denial notice dated August 19, 2022 upholding the initial denial. (Exhibit 5, p. 125).

CCA's representative referred to CCA and MassHealth criteria for ADH services and noted that the appellant does not requires physical, hands on assistance, or cueing and supervision with any ADLs. The CCA representative testified that the appellant does not require any of the skilled care services set forth in the criteria. A CCA reviewing nurse contacted the appellant's ADH program and spoke with one of the program's nurses. The ADH nurse reported that the appellant attends the ADH program for social reasons; the ADH nurses check his vital signs once a month; and the appellant is not exhibiting any behavioral needs. (Exhibit 5, p. 1). The ADH nurse stated further that the appellant is able to heat up meals and his daughter occasionally brings him hot meals. (Exhibit 5, p. 1). The CCA reviewing nurse also contacted the appellant's primary care clinician's (PCC) office and the medical team was not able to verbalize that the appellant required any skilled nursing service from the list of ADH criteria. (Exhibit 5, p. 1). The CCA reviewing nurse noted that based on the appellant's July 21, 2022 MDS assessment, the appellant is independent with ADLs and some IADLs; he receives bubble packed medications; he has informal family supports for financials and transportation; he is well connected with behavioral health services for his depression and PTSD. (Exhibit 5, p. 3). The CCA reviewing nurse noted that, based upon a review of the appellant's medical records, and conversations with the ADH program and his PCC's office, it was her recommendation to uphold the initial denial of the request for ADH services because the appellant does not meet CCA's or MassHealth's criteria for ADH. (Exhibit 5, p. 1).

Prior to the hearing, the appellant's representative submitted letters from the appellant's clinicians which were forwarded to CCA for review. (Exhibit 6). The CCA representative stated that the letters did not change CCA's determination. In a letter dated September 12, 2022, the appellant's psychiatric therapist wrote that the appellant should be able to keep participating in the ADH program in order to improve his daily living activity and quality of life. (Exhibit 6, p. 1). In a letter dated September 26, 2022, the appellant's physician reported that the appellant has aged related cataracts and age related macular degeneration, and chronic pain. (Exhibit 6, p. 2). The appellant's physician wrote that the appellant would benefit from going to the ADH program for multiple safety and well being concerns. (Exhibit 6, p. 2). The appellant had a medical appointment in August, 2022 and review of systems was negative, physical exam within normal limits. (Exhibit 6, p. 4).

The appellant's representative testified that she does not dispute the CCA representative's testimony and noted that the appellant is independent and does not have skilled care needs. The appellant's representative noted that the problem is the appellant's mental health. The appellant's representative noted that the appellant moved to the United States in 2017 and it has been difficult for him to adjust to his new life here. The appellant's representative stated that the appellant needed

something to do, so she paid for private day centers for the appellant but the people at those centers did not speak Spanish and the appellant felt out of place. The appellant's representative stated that the people spoke Spanish at the appellant's ADH program and they provided healthy meals. The appellant's representative noted that the appellant felt at home at the ADH program. The appellant's representative stated that the appellant gets depressed at home and has nothing to do. The appellant's representative stated that the appellant's only social life was at the ADH program. The appellant's representative stated that the appellant is healthy, but needs the ADH program for his social life.

Findings of Fact

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

1. The appellant is over age 65, lives alone, and has a primary diagnosis of hypertension; the appellant has secondary diagnoses including alcohol dependence in remission, age related cataracts and macular degeneration, pain, and major depressive disorder.

2. The appellant has been a member of CCA's Senior Care Options plan since February 1, 2020 and was in an ADH program at the time he enrolled in CCA's SCO.

3. The appellant's provider, Quality Life Adult Day Service, submitted a request for prior authorization for 5 days a week of ADH services to CCA on June 7, 2022.

4. The appellant had a MDS assessment on July 21, 2022.

5. The appellant is independent with ADLs and does not require at least daily, or on a regular basis, hands-on physical assistance or cueing and supervision, throughout the entire activity, with one or more qualifying ADLs.

6. The appellant does not require any skilled care services.

7. CCA denied the appellant's request for ADH services by notice dated July 27, 2022 and the appellant submitted an internal appeal on July 29, 2022.

8. The appellant's representative reported in the Level I appeal that the appellant suffers from depression and PTSD and enjoys going to ADH where he can interact with other Spanish speaking people.

9. The appellant attended the ADH program for social reasons; the ADH nurses checked his vital signs once a month; and the appellant did not exhibit any behavioral needs.

10. The appellant's PCC's office did not report that the appellant required any skilled nursing service.

11. The appellant receives bubble packed medications; he has informal family supports for financials and transportation; he is well connected with behavioral health services for his depression and PTSD.

12. The appellant had a medical appointment in August, 2022 and review of systems was negative, physical exam within normal limits.

Analysis and Conclusions of Law

Obtaining Services When Enrolled in a SCO (Senior Care Organization). When a member chooses to enroll in a senior care organization (SCO) in accordance with the requirements under 130 CMR 508.008, the SCO will deliver the member's primary care and will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, each SCO is required to provide evidence of its coverage, including a complete list of participating providers, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to covered services such as specialty, behavioral health, and long-term-care services. 130 CMR 508.008(C).

Senior Care Organization (SCO) – a managed care organization that participates in MassHealth under a contract with the MassHealth agency to provide coordinated care and medical services through a comprehensive network to eligible members 65 years of age or older. SCOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services. 130 CMR 610.004.

Clinical Assessment and Prior Authorization

(A) Clinical Assessment. As part of the prior authorization process, members seeking ADH (adult day health) must undergo a clinical assessment to assess the member's clinical status and need for ADH. Completed clinical assessment documentation must be submitted to the MassHealth agency or its designee in the form and format requested by the MassHealth agency. A new clinical assessment is required annually and upon significant change.

(B) Prior Authorization.

(1) As a prerequisite for payment of ADH, the ADH provider must obtain prior authorization from the MassHealth agency or its designee before the first date of service delivery and annually thereafter, or upon significant change.

(2) Prior authorization determines the medical necessity for ADH services as described under 130 CMR 404.405 and in accordance with 130 CMR 450.204: Medical Necessity.

(3) Prior authorization may specify the level of payment for ADH (as described under 130 CMR 404.414(D).

(4) Prior authorization does not establish or waive any other prerequisites for payment such as the member's financial eligibility described in 130 CMR 503.007: Potential Sources of Health Care and 517.008: Potential Sources of Health Care.

(5) When submitting a request for prior authorization for payment of ADH to the

MassHealth agency or its designee, the ADH provider must submit requests in the form and format as required by MassHealth. The ADH provider must include all required information, including, but not limited to, documentation of the completed clinical assessment conducted by the MassHealth agency or its designee; other nursing, medical or psychosocial evaluations or assessments; and any other documentation that the MassHealth agency or its designee requests in order to complete its review and determination of prior authorization.

(6) In making its prior authorization determination, the MassHealth agency or its designee, may require additional assessments.

130 CMR 404.406(A), (B).

Clinical Eligibility Criteria

(A) The MassHealth agency pays for ADH provided to members who meet all of the following clinical eligibility criteria:

(1) ADH has been ordered by the member's PCP;

(2) The member has one or more chronic or post-acute medical, cognitive, or mental health condition(s) identified by the member's PCP that require active monitoring, treatment or intervention and ongoing observation and assessment by a nurse, without which the member's condition will likely deteriorate;

(3) The member requires one or both of the following be provided by the ADH program:

(a) at least one skilled service listed in 130 CMR 404.405(B); or

(b) at least daily or on a regular basis hands-on (physical) assistance or cueing and supervision, throughout the entire activity, with one or more qualifying ADLs listed in 130 CMR 404.405(C) when required at the ADH program as determined clinically appropriate by the ordering PCP and the ADH program nurse developing the plan of care.

(B) Skilled Services. Skilled services are those services ordered by a physician that fall within the professional disciplines of nursing, physical, occupational, and speech therapy. Examples of skilled services include

(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 intervention including observation, evaluation or assessment, treatment and management to prevent exacerbation of one or more chronic medical and/or behavioral

health conditions at high risk for instability. Intervention must be needed at frequent intervals throughout the day;
(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, safety and the stabilization of the member's complex social determinants of health;
(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) Administration oversight, and management of medication by a licensed nurse including monitoring of dose, frequency, response and adverse reactions;
(10) evaluation, implementation, oversight and supervision by a licensed nurse of a behavior management plan and staff intervention required to manage, monitor, or alleviate the following types of behavior:

(a) wandering: moving with no rational purpose, seemingly oblivious to needs or safety; ongoing exit seeking behaviors; or elopement or elopement attempts;

(b) verbally abusive behavioral symptoms: threatening, screaming, or cursing at others;

(c) physically abusive behavioral symptoms: hitting, shoving, or scratching;

(d) socially inappropriate or disruptive behavioral symptoms: disruptive sounds, noisiness, screaming, self-abusive acts, disrobing in public, smearing or throwing food or feces, rummaging, repetitive behavior, eating non-food items, or causing general disruption, including difficulty in transitioning between activities;

(e) inability to self-manage care;

(f) pattern of disordered thinking, impaired executive functioning, confusion, delusions or hallucinations, impairing judgment and decision-making leading to lack of safety awareness and unsafe behavior and requiring frequent intervention during the day to maintain safety.

(11) medically necessary measurements of intake and output based on medical necessity to monitor and manage a chronic medical condition;
(12) gait evaluation and training administered or supervised by a registered physical therapist while at the ADH provider 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;
(13) 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);

(14) 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
(15) 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.

(C) Qualifying Activities of Daily Living for ADH Services. The list of ADLs in 130 CMR 404.405(C)(1) through (5) is for the purpose of clinical eligibility for receipt of ADH services.
(1) bathing—a full body bath or shower or a sponge (partial) bath which may include washing and drying of face, chest, axillae (underarms), arms, hands, abdomen, back and peri area that may include personal hygiene such as combing or brushing of hair, oral care, shaving, and when applicable applying make-up;
(2) toileting—member is incontinent (bladder or bowel) or requires scheduled assistance or routine catheter or colostomy care;
(3) transferring—member must be assisted or lifted to another position;
(4) mobility (ambulation) —member must be physically steadied, assisted or guided in mobility, or is unable to self-propel a wheelchair appropriately without the assistance of another person; and
(5) eating—member requires constant supervision and cueing during the entire meal or physical assistance with a portion or all of the meal.

130 CMR 404.405.

The appellant does not require at least one skilled service listed in 130 CMR 404.405(B) and is independent with ADLs. The appellant wants to continue attending the adult day health program because of the social support it provides and the opportunity to interact with other Spanish speaking people. MassHealth only covers adult day health services if the clinical criteria under 130 CMR 404.405 is met. Because the appellant's request does not meet the criteria for coverage under MassHealth regulations, CCA's determination is upheld and the appeal is denied.

Order for SCO

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.

Patricia Mullen
Hearing Officer
Board of Hearings

cc: MassHealth Representative: Commonwealth Care Alliance SCO, Attn: Cassandra Horne, 30 Winter Street, Boston, MA 02108

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