Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2410460
Decision Date:	08/23/2024	**Hearing Date:**	08/05/2024
Hearing Officer:	Radha Tilva		

Appearance for Appellant:
[redacted]

Appearances for MassHealth:
Kathleen Sheehan, Nurse Manager
Carol Jerusik, R.N., CAERF
Anna Johnson, CTLP, Case Manager

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:**	LTC - Screening
Decision Date:	08/23/2024	**Hearing Date:**	08/05/2024
MassHealth's Reps.:	Kathleen Sheehan, Carol Jerusik, Anna Johnson	**Appellant's Rep.:**	Pro se
Hearing Location:	Quincy Harbor South Tower	**Aid Pending:**	No

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 June 14, 2024, MassHealth determined that appellant is not clinically eligible for MassHealth payment of nursing facility services (see 130 CMR 456.409 and 456.408(A)(2) and Exhibit 1). The appellant filed this appeal in a timely manner on July 1, 2024 (see 130 CMR 610.015(B) and Exhibit 2). Denial of assistance is valid grounds for appeal (see 130 CMR 610.032).

Action Taken by MassHealth

MassHealth determined that appellant does not medically require nursing facility services.

Issue

The appeal issue is whether MassHealth was correct, pursuant to 130 CMR 456.409, in determining that appellant is not clinically eligible for MassHealth to pay for nursing facility services.

Summary of Evidence

The MassHealth representatives explained that a short-term review screen request was received on June 13, 2024 from [redacted] and completed on June 14, 2024 for a male resident in his [redacted] who was currently residing at the rehabilitation center following a fractured femur/hip in the community. Appellant's primary diagnoses included the following: history of intracapsular fracture of the right femur, fracture of ribs, fracture of first and second lumbar vertebrae, history of falls, hypertension, anemia (see Exhibit 5, p. 1). Appellant's medications include, but are not limited to, acetaminophen, amlodipine, ascorbic acid, calcium carbonate, and ferrous sulfate (*Id*.). The resident was admitted on December 21, 2023 for rehabilitation with a plan to discharge to the community once able to (MassHealth testimony). While at the facility on April 28, 2024, appellant was hospitalized with appendicitis with localized peritonitis and gangrene with abscess (*Id*.). He had a biopsy of a growth on his right breast on June 12, 2024, which was benign (*Id*.). All of the conditions resolved (*Id*.).

An onsite assessment was completed at [redacted] to review appellant's clinical eligibility status. The workers assigned to the assessment first met with a social worker from the facility who reported that the resident (appellant) is walking independently and is independent with activities of daily living. The social worker reported that the resident had left the facility with another resident and walked to the store to purchase cigarettes.

At the assessment, appellant reported that he was able to walk, but preferred to use a wheelchair. He also reported that he can go upstairs if he holds the railing, and is able to do his ADLs independently, including toileting. A nurse at the facility stated that she would provide education to the resident on the medications that he was taking. The appellant stated at the time of the assessment that he would be able to manage his medications in the community on his own. The doctor at the facility hasn't ordered any PT or OT for a while.

The MassHealth representative further explained that the resident is no longer receiving any skilled nursing services, PT or OT and is independent with all ADLs as noted on the CNA flow sheets. He no longer meets the clinical eligibility criteria for MassHealth payment for the skilled nursing facility stay. The nurse explained the MassHealth criteria for MassHealth payment for skilled nursing facility stay to the resident and explained why he no longer meets the criteria.

A nursing facility representative testified that they were working with him for options for discharge, and although they found out that he is homeless, he had an elderly aunt with whom he could live. The appellant, however, did not want to be a burden to her. Information was given to him about the Friends of Homeless program, transportation, and SSDI. A social worker has been working with him to help him with transitions.

The appellant represented himself at hearing and appeared by telephone. He testified to the following: he still needs therapy as he can only walk short distances, and spends most of his time in the chair and bed. He is independent with his upper body, but cannot bend or squat. He spends

most of the day in a chair and has a lot of pain. Living with his aunt is not an option for housing, as her health is not good. Being homeless and not having transportation are obstacles.

Findings of Fact

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

1. A short-term review screen request was received on June 13, 2024 from [redacted] West and completed on June 14, 2024 for a male resident in his [redacted], who was currently residing at the rehabilitation center following a fractured femur/hip in the community.

2. Appellant's primary diagnoses included the following: history of intracapsular fracture of the right femur, fracture of ribs, fracture of first and second lumbar vertebrae, history of falls, hypertension, and anemia.

3. An onsite assessment was completed on at [redacted] to review appellant's clinical eligibility status.

4. The MassHealth assessors first met with a social worker from the facility, who reported that the resident (appellant) is walking independently and is independent with activities of daily living.

5. At the assessment appellant reported that he was able to walk short distances, but preferred to use a wheelchair.

6. He also reported that he can go upstairs if he holds the railing, and is able to do his ADLs independently, including toileting.

7. The appellant requires no nursing care or has no skilled needs, but has a lot of pain and spends most of his day in bed or in the chair.

8. The appellant has no home or place to go other than a shelter.

Analysis and Conclusions of Law

<u>456.408: Conditions for Payment</u>
(A) The MassHealth agency pays for nursing facility services if ***all of*** the following conditions are met.

(1) The MassHealth agency or its designee has determined that individuals 22 years of age or older meet the nursing facility services requirements of 130 CMR 456.409 or the multi-

disciplinary medical review team coordinated by the Department of Public Health has determined that individuals 21 years of age or younger meet the criteria of 130 CMR 519.006(A): Eligibility Requirements.

(2) The MassHealth agency or its designee has determined that community care is either not available or not appropriate to meet the individual's needs.

(3) The requirements for the pre-admission screening and resident review (PASRR) process in 130 CMR 456.410 and as required by sub-regulatory guidance have been met. Failure to follow applicable PASRR rules will result in denial of MassHealth payments to the nursing facility for MassHealth members during the period of noncompliance pursuant to 42 CFR 483.122.

(B) The MassHealth agency pays for nursing facility services beginning with the date of financial eligibility provided that the member shows that they were medically eligible for these services as of the date of financial eligibility. If the member was not medically eligible for nursing facility services as of the first date of financial eligibility, the MassHealth agency will pay for these services beginning on the first date the member is medically eligible, provided that this date is after the first date of financial eligibility. A person may request a determination of medical eligibility at or after application for MassHealth.

456.409: Clinical Eligibility Criteria

To be considered clinically eligible for nursing facility services, a member or MassHealth 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 CMR456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C). Additionally, to be considered clinically eligible for nursing facility services, a member or MassHealth applicant younger than 22 years of age must also meet criteria as determined by the multi-disciplinary medical review team coordinated by the Department of Public Health.

(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 or PCP 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 or PCP 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- or PCP-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- or PCP-ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals);

(7) physician- or PCP-ordered 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 or PCP orders, or routine changing of dressings that require nursing care and monitoring.

(Emphasis added)

The evidence supports that the appellant does not require any skilled services, assistance with daily activities, or nursing services. Although the appellant asserted that he can only walk short distances, this does not demonstrate that he requires assistance with mobility, which requires that he needs the assistance of another person. Moreover, while the appellant may benefit from additional physical therapy, the regulations do not treat the need for physical therapy as a skilled or nursing service unless they are part of an active treatment plan. Appellant's ability to secure housing is not a factor in this appeal, which is limited to the issue of appellant's clinical eligibility. If appellant disagrees with any discharge plan proposed by the nursing facility, he may raise this argument if and when he appeals a notice of discharge.

Thus, he does not meet the clinical eligibility requirements under 130 CMR 456.409 and MassHealth did not err in making its determination.

For the foregoing reasons this appeal is DENIED.

Order for MassHealth

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.

Radha Tilva
Hearing Officer
Board of Hearings

cc: Respondent Representative: Carole Jerusik, RN, Greater Springfield Senior Services, Inc., 66 Industry Avenue, Suite 9, Springfield, MA 01104

MassHealth Representative: Desiree Kelley, RN, BSN, Massachusetts Executive Office of Elder Affairs, 1 Ashburton Pl., 3rd Floor, Boston, MA 02108