Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2411763
Decision Date:	10/04/2024	**Hearing Date:**	09/04/2024
Hearing Officer:	Marc Tonaszuck		

Appearance for Appellant:

Pro se

Appearance for Commonwealth Care Alliance (CCA) Integrated Care Organization (ICO):
Cassandra Horne, Appeals and Grievances Manager; Jeremiah Mancuso, RN, Clinical Nursing Appeals and Grievances Manager; Kaley Ann Emery, Appeals Supervisor; Amy Stebbins, Utilization Manager for Personal Care Attendant Program

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:**	Managed Care Organization – Denial of Internal Appeal
Decision Date:	10/04/2024	**Hearing Date:**	09/04/2024
Commonwealth Care Alliance's Reps.:	C. Horne, Appeals and Grievances Manager; J. Mancuso, RN, Clinical Nursing Appeals and Grievances Manager; K. Emery, Appeals Supervisor; A. Stebbins, Utilization Manager for Personal Care Attendant Program	**Appellant's Rep.:**	Pro se
Hearing Location:	Springfield MassHealth Enrollment Center	**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

The appellant, a member of Commonwealth Care Alliance ("CCA"), a MassHealth Integrated Care Organization ("ICO"), received a notice from CCA dated 07/12/2024 modifying the appellant's request for personal care attendant ("PCA") services (Exhibit 1). The appellant filed this appeal with the Board of Hearings in a timely manner on 07/29/2024 (130 CMR 610.015(B); Exhibit 2). Members enrolled in an ICO have a right to request a fair hearing for a decision to deny or provide limited

authorization of a requested service, provided the member has exhausted all remedies available through the ICO's internal appeals process (130 CMR 610.032(B)(2)). The appellant exhausted CCA's internal appeals process.

Action Taken by MassHealth

CCA modified the appellant's request for an increase of PCA services from a requested 41:30 (41 hours and 30 minutes) hours per week to 32:00 hours per week.

Issue

Was CCA correct to modify the appellant's request for PCA services from a requested 41:50 hours per week to 32:00 hours per week?

Summary of Evidence

The appellant appeared at the fair hearing. Several representatives from CCA appeared virtually at the fair hearing and they referenced a packet that was submitted prior to the fair hearing. Exhibits 1-4 were submitted to the hearing record.

Ms. Horne testified for CCA that this case involves the appellant, a MassHealth member, who has been enrolled in CCA's ICO. CCA's ICO manages the appellant's health care needs. Ms. Horne testified that appellant was previously approved for 31 hours per week of PCA assistance based on the telephonic PCA evaluation conducted 3/28/2023. The appellant had her annual PCA reassessment on 3/16/2024, and her PCA provider, [redacted] ("provider") requested an increase to 41.5 hours per week. After reviewing recent physical therapy, vascular surgery and RN assessment notes, CCA Utilization Management department reduced the PCA increase time to 32 hours per week.

The appellant's request for an increase of PCA time was modified by CCA on 06/10/2024. The appellant made a level 1 request for reconsideration on 06/16/2024. The CCA Medical Director reviewed the decision and on 07/11/2024, the level 1 request was denied by CCA. There are three tasks where CCA modified the request for PCA services: mobility; dressing/lymphedema treatment; and medication pre-fill.

<u>Mobility</u>

The appellant's PCA provider requested 3 minutes, 10 times per day, 7 days per week (3 X 10 X 7) for assistance with mobility. CCA modified the request for assistance with mobility to 1 X 10 X 7. The provider documented that the appellant needs "moderate assist" but also be "contact

guard." This is a contradiction, as contact guard indicates member needs no other assistance other than 1-2 hands placed on their body to help with balance. Moderate assistance means the member needs the PCA to provide up to 50% of physical assistance with that task. Per member's physical therapy notes, member was able to ambulate 400 feet without an assisted device by day 2 (4/12/2024). The assessment completed on 4/19/2024 states that appellant only requires supervision for indoor ambulation and transfers. The appellant's annual wellness visit, also done on 4/19/2024 by CCA nurse practitioner states, "Mobility/Falls: Member's mobility is limited by pain, morbid obesity, COPD and poor endurance. She uses a rollator for mobility. Member reports a fall back in September 2023. Member had follow-up treatment at the emergency department and with primary care physician for fall." CCA's reduction for mobility is 1 X 10 X 7 is reasonable for this task, which involves assistance getting up and down from a seated position to a standing position or to and from another location in the home. This task does not include transfers to/from the bathroom or to/from the bed.

The appellant testified with the assistance of [redacted], her PCA. The appellant admitted she did not know how much time it took for the PCA to assist her with mobility. She stated, "I have to take my time and I lose balance." The PCA assists her so that she does not "fall over."

Dressing/Lymphedema Treatment

The appellant's PCA provider requested 20 X 2 X 7 for assistance applying and removing the appellant's compression devises to treat her lymphedema. CCA reduced the requested time, as it included lymphedema treatments which were not documented in her clinical record. Member's lymphedema is managed by her vascular surgeon, who recently ordered her an advanced compression system called Flexitouch. Per vascular surgeon clinical note at most recent visit on 6/05/2024, this states "She uses the Flexitouch system and wears her Circaid wraps daily. She is very satisfied with the effect that these treatments have had on her legs." The appellant's lymphedema supplies are listed on her medications, but there is no mention of wound care supplies. Systems were reviewed, and this states, "patient denies ... ulcerations in the legs or feet.", "Patient denies.. heavy sweating, itching, rashes, skin lesions and ulcers." This states "On physical exam today, the appearance of the lower legs has significantly improved, and the edema has lessened. The skin is soft and supple with no ulcers." "Assessment/Plan: In summary, [the appellant has] advanced lymphedema. She is controlling her symptoms well with the use of Flexitouch and Circaid compression. CCA approved 5 X 2 X 7 for assistance donning/doffing the Circaid wraps and 5 X 2 X 7 for assistance with the Flexitouch compression system.

The appellant stated 5 minutes is "about right," for PCA assistance with each of these tasks.

Medication Pre-Fill

The appellant's PCA provider requested 10 X 1 X 1 for assistance pre-filling the appellant's medication planner. CCA denied the time requested for assistance with medication pre-fill. The

CCA representative testified that per the notes from the nurse practitioner dated 4/19/2024, "Member is independent with medication management. Member was able to state the dosage, times, and uses of all medications." Per the nursing assessment also on 4/19/2024, "Managing Medications: How medications are managed (e.g. remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments): Independent - did on own; No Difficulty." CCA concluded that because the documentation states the appellant is independent with this task, no PCA time was approved.

The appellant testified that her PCA assists her with preparing a 14-day planner for her medications. She stated, "I have to go slow. I hand him the bottles." Some of her medications stay in the refrigerator. The appellant reads the list and the PCA puts the medications in the containers. The appellant testified that it takes about 33 minutes every two weeks to perform this task.

Findings of Fact

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

1. The appellant is a MassHealth member who is enrolled in Commonwealth Care Alliance ("CCA's") integrated care organization ("ICO").

2. CCA's ICO manages the appellant's health care needs.

3. CCA previously approved the appellant for 31 hours per week of PCA assistance based on the telephonic PCA evaluation conducted 3/28/2023.

4. The appellant had her annual PCA reassessment on 3/16/2024, and her PCA provider, [redacted] ("provider"), requested an increase to 41.5 hours per week.

5. On 06/10/2024, CCA modified the appellant's request for an increase of PCA time to 32:00 hours per week of assistance.

6. The appellant made a level 1 request for reconsideration to CCA on 06/16/2024.

7. The CCA Medical Director reviewed the decision and on 07/11/2024, the level 1 request was denied by CCA.

8. The appellant exhausted CCA's internal appeal process.

9. On 07/29/2024, the appellant appealed CCA's level 1 denial to the Board of Hearings.

10. A fair hearing took place before the Board of Hearings on 09/04/2024.

11. There are three tasks where CCA modified the request for PCA services: mobility; dressing/lymphedema treatment; and medication pre-fill.

12. The appellant's PCA provider requested 3 minutes, 10 times per day, 7 days per week (3 X 10 X 7) for assistance with mobility. The provider documented that the appellant needs "moderate assist" but also be "contact guard."

13. CCA modified the appellant's request for assistance with mobility to 1 X 10 X 7.

14. Assistance with mobility is assisting the appellant up and down from the seated position, and to and from one part of the home to another. Mobility does not include transfers for toileting, bathing, or dressing.

15. CCA's physical therapy notes state that the appellant was able to ambulate 400 feet without an assisted device by day 2 (4/12/2024). The assessment completed on 4/19/2024 states that appellant only requires supervision for indoor ambulation and transfers. The appellant's annual wellness visit, also done on 4/19/2024 by CCA nurse practitioner states, "Mobility/Falls: Member's mobility is limited by pain, morbid obesity, COPD and poor endurance. She uses a rollator for mobility" (Exhibit 4).

16. The appellant's PCA provider requested 20 X 2 X 7 for assistance applying and removing the appellant's compression devices and wraps to treat her lymphedema.

17. CCA modified the request for assistance applying and removing the compression wraps to 5 X 2 X 7.

18. CCA modified the request for assistance using the compression device to 5 X 2 X 7.

19. The appellant agreed that 5 minutes for each of these tasks "is about right."

20. The appellant's PCA provider requested 10 X 1 X 1 for assistance pre-filling the appellant's medication planner.

21. CCA denied the request for PCA assistance to pre-fill the medication planner.

22. Per the notes from the nurse practitioner dated 4/19/2024, "Member is independent with medication management. Member was able to state the dosage, times, and uses of all medications." Per the nursing assessment also on 4/19/2024, "Managing Medications: How medications are managed (e.g. remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments): Independent - did on own; No Difficulty" (Exhibit 4).

Analysis and Conclusions of Law

The regulatory definition of medical necessity is set forth at 130 CMR 450.204. 130 CMR 450.204(A) and (B) state as follows:

The MassHealth agency will not pay a provider for services that are not medically necessary and may impose sanctions on a provider for providing or prescribing a service or for admitting a member to an inpatient facility where such service or admission is not medically necessary.

(A) 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 the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency 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.

(B) Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records, including medical records, available to the MassHealth agency upon request. (See 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)

Regulations at 130 CMR 422.412 describe non-covered PCA services:

MassHealth does not cover any of the following as part of the PCA program or the transitional living program:

(A) social services, including, but not limited to, babysitting, respite care, vocational rehabilitation, sheltered workshop, educational services, recreational services, advocacy, and liaison services with other agencies;
(B) medical services available from other MassHealth providers, such as physician, pharmacy, or community health center services;

(C) ***assistance provided in the form of cueing, prompting, supervision, guiding, or coaching;***
(D) PCA services provided to a member while the member is a resident of a nursing facility or other inpatient facility;
(E) PCA services provided to a member during the time a member is participating in a community program funded by MassHealth including, but not limited to, day habilitation, adult day health, adult foster care, or group adult foster care;
(F) services provided by family members, as defined in 130 CMR 422.402; or
(G) surrogates, as defined in 130 CMR 422.402.

To qualify for services under the PCA program, the member must meet the conditions defined at 130 CMR 422.403, below:

(C) MassHealth covers personal care services provided to eligible MassHealth members who can be appropriately cared for in the home when all of the following conditions are met:

(1) The personal care services are prescribed by a physician or a nurse practitioner who is responsible for the oversight of the member's health care.
(2) The member's disability is permanent or chronic in nature and impairs the member's functional ability to perform ADLs and IADLs without physical assistance.
(3) The member, as determined by the personal care agency, requires physical assistance with two or more of the following ADLs as defined in 130 CMR 422.410(A):
(a) mobility, including transfers;
(b) medications,
(c) bathing/grooming;
(d) dressing or undressing;
(e) range-of-motion exercises;
(f) eating; and
(g) toileting
(4) The MassHealth agency has determined that the PCA services are medically necessary and has granted a prior authorization for PCA services.

The type of PCA services available are described in 130 CMR 422.410 below:

(A) Activities of Daily Living (ADLs). Activities of daily living include the following:
(1) mobility: physically assisting a member who has a mobility impairment that prevents unassisted transferring, walking, or use of prescribed durable medical equipment;
(2) assistance with medications or other health-related needs: physically assisting a member to take medications prescribed by a physician that otherwise would be self-administered;

(3) bathing/grooming: physically assisting a member with basic care such as bathing, personal hygiene, and grooming skills;
(4) dressing or undressing: physically assisting a member to dress or undress;
(5) passive range-of-motion exercises: physically assisting a member to perform range-of motion exercises;
(6) eating: physically assisting a member to eat. This can include assistance with tubefeeding and special nutritional and dietary needs; and
(7) toileting: physically assisting a member with bowel and bladder needs.

(B) Instrumental Activities of Daily Living (IADLs). Instrumental activities of daily living include the following:
(1) household services: physically assisting with household management tasks that are incidental to the care of the member, including laundry, shopping, and housekeeping;
(2) meal preparation and clean-up: physically assisting a member to prepare meals;
(3) transportation: accompanying the member to medical providers; and
(4) special needs: assisting the member with:
(a) the care and maintenance of wheelchairs and adaptive devices;
(b) completing the paperwork required for receiving personal care services; and
(c) other special needs approved by the MassHealth agency as being instrumental to the health care of the member.

(C) Determining the Number of Hours of Physical Assistance. In determining the number of hours of physical assistance that a member requires under 130 CMR 422.410(B) for IADLs, the personal care agency must assume the following.
(1) When a member is living with family members, the family members will provide assistance with most IADLs. For example, routine laundry, housekeeping, shopping, and meal preparation and clean-up should include those needs of the member.
(2) When a member is living with one or more other members who are authorized for MassHealth personal care services, PCA time for homemaking tasks (such as shopping, housekeeping, laundry, and meal preparation and clean-up) must be calculated on a shared basis.
(3) The MassHealth agency will consider individual circumstances when determining the number of hours of physical assistance that a member requires for IADLs.

(***Emphasis added***.)

Regulations at 130 CMR 508.007(C) address Integrated Care Organizations as follows:

(C) Obtaining Services When Enrolled in an ICO. When a member is enrolled in an ICO in accordance with the requirements under 130 CMR 508.007(A), the ICO will authorize, arrange, integrate, and coordinate the provision of all covered services for the member.

> Upon enrollment, the ICO is required to provide evidence of its coverage, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to specialty, behavioral health, and long-term services and supports.

Fair hearing regulations at 130 CMR 610.032(B) describe appeal rights of ICO members:

> Members enrolled in a managed care contractor have a right to request a fair hearing for any of the following actions or inactions by the managed care contractor, provided the member has exhausted all remedies available through the managed care contractor's internal appeals process (except where a member is notified by the managed care contractor that exhaustion is unnecessary):
>
> (1) failure to provide services in a timely manner, as defined in the information on access standards provided to members enrolled with the managed care contractor;
> (2) a decision to deny or provide limited authorization of a requested service, including the- type or level of service, including determinations based on the type or level of service, requirements for medically necessity, appropriateness, setting, or effectiveness of a covered benefit;
> (3) a decision to reduce, suspend, or terminate a previous authorization for a service;
> …

The appellant has the burden "to demonstrate the invalidity of the administrative determination." See *Andrews vs. Division of Medical Assistance*, 68 Mass. App. Ct. 228. Moreover, the burden is on the appealing party to demonstrate the invalidity of the administrative determination. See *Fisch v. Board of Registration in Med.*, 437 Mass. 128, 131 (2002); *Faith Assembly of God of S. Dennis & Hyannis, Inc. v. State Bldg. Code Commn*., 11 Mass. App. Ct. 333 , 334 (1981); *Haverhill Mun. Hosp. v. Commissioner of the Div. of Med. Assistance*, 45 Mass. App. Ct. 386 , 390 (1998).

The appellant, a MassHealth member, is enrolled in CCA's ICO. During the last approval period, the appellant was approved for 31:00 day/evening PCA hours per week. The appellant had her annual PCA reassessment on 3/16/2024, and her PCA provider, [redacted] ("provider") requested an increase to 41.5 hours per week. After reviewing recent physical therapy, vascular surgery and RN assessment notes, CCA's Utilization Management department modified the PCA increase time to 32 hours per week. There are three tasks where CCA modified the request for PCA services: mobility; dressing/lymphedema treatment; and medication pre-fill.

The appellant's request for an increase of PCA time was modified by CCA on 06/10/2024. The appellant made a level 1 request for reconsideration on 06/16/2024. The CCA Medical Director reviewed the decision and on 07/11/2024, the level 1 request was denied by CCA. The appellant appealed to the Board of Hearings.

Mobility

The appellant's PCA provider requested 3 minutes, 10 times per day, 7 days per week (3 X 10 X 7) for assistance with mobility. The provider documented that the appellant needs "moderate assist" but also be "contact guard." CCA modified the appellant's request for assistance with mobility to 1 X 10 X 7. CCA correctly testified that assistance with mobility is assisting the appellant up and down from the seated position, and to and from one part of the home to another. Mobility does not include transfers for toileting, bathing, or dressing. CCA's physical therapy notes state that the appellant was able to ambulate 400 feet without an assisted device by day 2 (4/12/2024). The assessment completed on 4/19/2024 states that appellant only requires supervision for indoor ambulation and transfers. The appellant's annual wellness visit, also done on 4/19/2024 by CCA nurse practitioner states, "Mobility/Falls: Member's mobility is limited by pain, morbid obesity, COPD and poor endurance. She uses a rollator for mobility."

The appellant testified that she needs assistance with mobility "to make sure I don't fall over." She was not able to testify to the amount of hands-on assistance the PCA provides her with mobility. CCA's modification is supported by the facts in the hearing record as well as the above regulations. The appellant requires assistance in the form of cueing, prompting, supervision, guiding, or coaching, as she testified to. This is a non-covered service by the PCA program. The appellant has not shown that CCA's modified time for this task does not meet her needs. Accordingly, this portion of the appeal is denied.

Dressing/Lymphedema Treatment

The appellant's PCA provider requested 20 X 2 X 7 for assistance applying and removing the appellant's compression devices and wraps to treat her lymphedema. CCA modified the request for assistance applying and removing the compression wraps to 5 X 2 X 7 and the time for assistance using the compression device to 5 X 2 X 7. The appellant agreed that 5 minutes of assistance for each of these tasks "is about right." This portion of the appeal is therefore denied.

Medication Pre-Fill

The appellant's PCA provider requested 10 X 1 X 1 for assistance pre-filling the appellant's medication planner. CCA denied the request for PCA assistance to pre-fill the medication planner. Per the notes from the nurse practitioner dated 4/19/2024, "Member is independent with medication management. Member was able to state the dosage, times, and uses of all medications." Per the nursing assessment also on 4/19/2024, "Managing Medications: How medications are managed (e.g. remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments): Independent - did on own; No Difficulty."

The appellant explained that the PCA assists her with pre-filling her medication planner every two weeks. She explained how they work together; however, she did not explain why she was unable

to independently pre-fill her medication planner. As a result, CCA's modification is supported by the facts in the hearing record and the regulations. This portion of the appeal is denied.

For the foregoing reasons, this appeal is denied.

Order for CCA

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.

_____

Marc Tonaszuck
Hearing Officer
Board of Hearings

MassHealth Representative: Commonwealth Care Alliance SCO, Attn: Nayelis Guerrero, 30 Winter Street, Boston, MA 02108