Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2418732
Decision Date:	02/25/2025	**Hearing Date:**	01/10/2025
Hearing Officer:	Emily Sabo		

Appearances for Appellant:

[redacted]

Appearances for MassHealth:

Donna Chesna, R.N., Nurse Manager, [redacted] Linda Brissette, Supervisor, [redacted]; Paula Rigerio-Coffey, ASAP R.N., [redacted]

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:**	Nursing Facility Screening
Decision Date:	02/25/2025	**Hearing Date:**	01/10/2025
MassHealth's Reps.:	Donna Chesna, Linda Brissette, Paula Rigerio-Coffey	**Appellant's Reps.:**	[redacted]
Hearing Location:	Quincy Harbor South (Telephone)	**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

By notice dated November 19, 2024, MassHealth informed the Appellant that she is eligible for MassHealth payment of nursing facility services because such services were medically necessary. 130 CMR 456.409 and Exhibit 1. The Appellant filed this appeal in a timely manner on December 9, 2024. 130 CMR 610.015(B) and Exhibit 2. Challenging MassHealth decisions regarding scope and amount of assistance is a valid basis for appeal. 130 CMR 610.032.

Action Taken by MassHealth

MassHealth informed the Appellant that the Appellant was clinically eligible for MassHealth payment of nursing facility services (long-term).

Issue

The appeal issue is whether MassHealth was correct in determining that the Appellant was clinically eligible for payment of nursing facility services on a long-term, and not short-term, basis.

Summary of Evidence

MassHealth utilizes Aging Services Access Point (ASAP) organizations to perform clinical evaluations of MassHealth members to determine members' clinical eligibility for nursing facility services. A nurse and two managers from [redacted] Area ("the ASAP representatives") appeared at the hearing by phone and submitted documents in support. Exhibit 5. The Appellant appeared by phone and was represented by her two daughters, one of whom is the Appellant's invoked health care proxy. They verified the Appellant's identity. A summary of evidence and testimony follows.

The Appellant is [redacted] and suffers from vascular dementia. The Appellant was admitted to the nursing facility on [redacted] after being hospitalized following a suspected fall and possible stroke, garbled speech, and dizziness. The Appellant's medical history includes occlusion and stenosis of cerebral artery, type 2 diabetes, dysphagia, abnormalities of gait and mobility, muscle weakness, malignant neoplasm of pharynx, hypothyroidism, hyperlipidemia, hypertension, and a history of falls. The Appellant also has stage 2 head and neck cancer. Prior to her hospitalization, the Appellant was living in an assisted living facility. The Appellant's health care proxy was invoked on October 1, 2024.

On October 31, 2024, the nursing facility submitted a request to MassHealth for services for long-term care conversion. The nursing facility requested a conversion date of October 26, 2024, and the ASAP nurse completed an evaluation on November 18, 2024. The ASAP nurse testified that she approved the Appellant for nursing facility services on a long-term basis because of the Appellant's cognitive decline and frailty. The ASAP nurse testified that it would not have been safe to discharge the Appellant to her former assisted living facility due to the Appellant's care needs. The ASAP nurse consulted with the nursing facility's unit nurse manager and director of nursing, who reported that the Appellant would be staying at the facility long-term based on her needs. The Appellant experienced falls at the facility on three successive dates in October and also lost weight. The ASAP nurse testified that she had a phone conversation with the Appellant's invoked healthcare proxy, who agreed with the Appellant's long-term placement. The ASAP nurse determined that the Appellant met the clinical criteria for nursing facility services based on her dementia diagnosis and 130 CMR 456.409(A)(7) and (12); (B)(1), (2), (3), (4), (5), and (6); and (C)(4), (5), and (7). The ASAP representative testified that afterwards, the Appellant's healthcare proxy called to request that the Appellant's placement be changed to a short-term placement because that would be financially beneficial to the Appellant.

The Appellant's healthcare proxy testified that she did not agree with the ASAP nurse's testimony. The Appellant's healthcare proxy testified that the Appellant was making progress on October 26, 2024, that short-term rehab would have been appropriate, and that they paid for the Appellant's November 2024 rent at the assisted living facility with the goal of saving her bed so that she could

return there. The Appellant's healthcare proxy testified that in October and November 2024, the Appellant's family were considering alternatives to the Appellant remaining at the nursing facility long-term. These options included private care, and the Appellant returning to the assisted living facility. The Appellant's healthcare proxy testified that she visited the Appellant daily, met with her care team and participated in the Appellant's care plan meetings, and at no point was it discussed that it would be unsafe for the Appellant to be discharged to the assisted living facility.

The ASAP nurse responded that the Appellant's healthcare proxy had not told her that the Appellant's bed was being held at the assisted living facility. The ASAP nurse testified that the long-term placement decision for the Appellant was clinically appropriate.

Findings of Fact

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

1. The Appellant was admitted to the nursing facility on [redacted] after a hospitalization following a suspected fall and possible stroke (Testimony, Exhibit 5).

2. The Appellant had previously been living in an assisted living facility (Testimony).

3. The Appellant is [redacted] and has vascular dementia (Testimony, Exhibit 5).

4. On October 1, 2024, the Appellant's healthcare proxy was invoked (Exhibit 2).

5. On October 31, 2024, the nursing facility submitted a request to MassHealth for long-term care conversion for the Appellant. The nursing facility requested a conversion date of October 26, 2024 (Exhibit 5).

6. In October 2024, the Appellant fell at the nursing facility on three successive dates (Testimony, Exhibit 5).

7. By notice dated November 19, 2024, MassHealth notified the Appellant that she was clinically eligible for MassHealth payment of nursing facility services on a long-term, not short-term, basis (Exhibit 1).

8. The Appellant's healthcare proxy filed this appeal in a timely manner on December 9, 2024 (Exhibit 2).

Analysis and Conclusions of Law

Pursuant to 130 CMR 456.408:

> (A) The MassHealth agency pays for nursing-facility services if all of the following conditions are met.
>
> > (1) The MassHealth agency 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) The MassHealth agency 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.

Further, under 130 CMR 456.409:

> 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 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.

The regulations contain no clinical distinction between eligibility for MassHealth payment of nursing facility services on a short-term basis or on a long-term basis. The Executive Office of Elder Affairs Program Instructions (EOEA PI – 22 – 07, dated December 27, 2022), outline the requirements for ASAPs determining clinical eligibility for MassHealth payment for nursing facility services and provide another point of reference. Exhibit 5 at 123-137. According to EOEA PI-22-07, a short-term approval (STA) is defined as a "clinical determination for an approval issued by an ASAP R.N. when a MassHealth Member/applicant meets the clinical criteria for MassHealth payment of Nursing Facility services **and requires time in a Nursing Facility to rehabilitate or recuperate.**" Exhibit 4 at 126 (emphasis added). An STA is issued with a specific end date, and the maximum length for which an STA can be issued is six months. *Id*. at 134. Alternatively, a long-term approval is issued "when the MassHealth Member/applicant meets the clinical criteria for MassHealth payment of Nursing Facility services **for an indefinite length of stay after all attempts to overcome identified barriers to discharge have ended**." *Id*. (emphasis added). Long-term approval is for authorization for MassHealth payment of nursing facility services given with no end date. *Id.* Long-term approval may only be given as an initial approval if the member meets at least one of four criteria, one of which is that they have "a confirmed diagnosis of Alzheimer's disease or related dementia and supervision for consistent interventions for safety are needed." *Id.*

Individuals who are approved for MassHealth coverage of a nursing facility stay must contribute to the cost of care with a patient-paid amount (PPA) owed to the facility. 130 CMR 515.001. MassHealth calculates the PPA based on the member's countable income less certain deductions as set forth in 130 CMR 520.009. Included in these deductions is a home-maintenance allowance, an amount tied to the federal poverty level and available to members who are certified likely to return home within six months after the month of admission. 130 CMR 520.026(D). In this case, no specific testimony was given regarding the Appellant's PPA or home-maintenance allowance. MassHealth Eligibility Operations Memo (EOM) 23-16 prohibits applicants or nursing facilities from requesting that a screening nurse change the nursing facility clinical approval of a level of care conversion screening so that the applicant can get a home maintenance needs allowance.[1]

Here, the ASAP nurse determined that the Appellant met the clinical criteria for nursing facility services based on her dementia diagnosis and 130 CMR 456.409(A)(7) and (12); (B)(1), (2), (3), (4), (5), and (6); and (C)(4), (5) and (7). The parties do not dispute whether the Appellant meets the clinical criteria for a nursing facility stay. The parties only dispute whether the Appellant was

[1] This EOM is available at: https://www.mass.gov/doc/eom-23-16-level-of-care-conversion-screening-process-updated-0/download.

appropriately approved for long-term care as opposed to a short-term stay on November 19, 2024.

According to EOEA PI-22-07, whether the Appellant should have been screened short- versus long-term hinges on whether Appellant could discharge by a specific date or required an indefinite length of stay. While I understand the Appellant's healthcare proxy's testimony that the Appellant's family was considering other alternatives, including her returning to the assisted living facility, there was no testimony or evidence in the record to suggest that the Appellant was recuperating such that she could be discharged by a specific, anticipated date. Accordingly, the Appellant has not met her burden of establishing that the ASAP's determination to approve her for long-term care coverage was made in error.

Accordingly, 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.

Emily Sabo

Hearing Officer
Board of Hearings

cc: [redacted]

cc: Respondent Representative: Paula Rigiero-Coffey, R.N., [redacted]

cc: MassHealth Representative: Desiree Kelley, R.N., B.S.N., Massachusetts Executive Office of Elder Affairs, 1 Ashburton Pl., 3rd Floor, Boston, MA 02108