Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Approved in Part; Denied in Part	**Appeal Number:**	2505153
Decision Date:	6/30/2025	**Hearing Date:**	05/08/2025
Hearing Officer:	Christopher Jones		

Appearances for Appellant:

[redacted]

Appearances for MassHealth:
Linda Phillips, RN, BSN, LNC-CSp.
Kelly Macero, RN
Jennifer Pittsley, RN, BSN

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:	Approved in Part; Denied in Part	**Issue:**	Community Case Management (CCM)
Decision Date:	6/30/2025	**Hearing Date:**	05/08/2025
MassHealth's Reps.:	Linda Phillips, RN, BSN, LNC-CSp.; Kelly Macero, RN; Jennifer Pittsley, RN, BSN	**Appellant's Reps.:**	[redacted]
Hearing Location:	Virtual	**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 letter dated January 30, 2025, the MassHealth Community Case Management ("CCM") program documented the outcome of a clinical Needs Assessment that had been performed on October 30, 2024. This assessment approved the appellant for 114 hours per week of continuous skilled nursing (CSN") services.[1] (Exhibit 1; Exhibit 8, pp. 94-101.) The appellant filed this timely appeal on March 31, 2025. (Exhibit 3. 130 CMR 610.015(B).) Individual MassHealth determinations regarding scope and amount of assistance are grounds for appeal. (130 CMR 610.032(A)(5).)

The Board of Hearings initially dismissed the appeal on April 1, 2025, before issuing the scheduling notice on April 8, 2025. (See Exhibit 5; Exhibit 6.)

Action Taken by MassHealth

MassHealth approved fewer CSN hours than the appellant wanted.

[1] Five percent of the total hours, 6 additional hours, were approved for administrative and documentation time. This brings the total nursing hours to 120 hours per week.

Issue

The appeal issue is whether Appellant qualifies for additional continuous skilled nursing services.

Summary of Evidence

Linda Phillips, the Associate Director of Appeals and Regulatory Compliance for MassHealth's Community Case Management ("CCM") program, was the principal representative on the agency's behalf. Ms. Phillips testified that CCM authorizes and coordinates MassHealth Long Term Services and Supports ("LTSS"), including continuous skilled nursing ("CSN") services, for MassHealth members with complex medical needs and their caregivers. Clinical Managers, or CMs, are registered nurses who coordinate and approve services on behalf of MassHealth and provide a point of contact for members.

The appellant is a young adult who enrolled with CCM on February 2, 2022. The appellant's primary diagnosis is Lennox-Gastaut Syndrome, a severe seizure disorder, which is complicated by the appellant's underlying Pitt Hopkins syndrome. Pitt Hopkins syndrome is a genetic condition that causes developmental delays and significantly impacts the respiratory system.

[redacted] is the appellant's treating neurologist. [redacted] had limited time to participate in the hearing, and her testimony was provided first as background on the appellant's clinical condition. [redacted] began treating the appellant in 2007, when the medical care team was still developing diagnoses for the appellant's unusual clinical characteristics. At the time, the appellant had not yet developed seizures, but he started developing seizures in 2009. Since that time, the appellant's seizures have become more dangerous and controlling the appellant's seizures has become more difficult. The seizure disorder suppresses the appellant's respiratory system, which is already compromised due to his genetic condition. The appellant's breathing can stop completely during a seizure. In 2019, the appellant had a breathing tube and feeding tube placed due to this increased risk.

[redacted] explained that the appellant is unique in terms of types and presentation of seizures. [redacted] and the appellant's mother reviewed 6 to 7 types of seizures that the appellant can suffer, each of which have different clinical symptoms. The variety of seizures and seizure signals make monitoring the appellant very difficult. The appellant's vital signs need to be monitored, but it is not sufficient to simply have him connected to monitoring devices. [redacted] testified that there is no perfect seizure detection system that could be used in a home. Many of the appellant's seizures are detected through visual observations by a nurse or the appellant's mother, and some of the signals are so innocuous that the nurses need to be trained to identify them. If the appellant is having a seizure and stops breathing, this would not register on an oxygen sensor until the appellant was already critically hypoxic due to the delay from measuring blood oxygenation. Sometimes, his seizures cause hyperventilation, others result in muscular contractions of his lungs and stomach that can cause vomiting, which is an aspiration risk.

[redacted] testified that the appellant's seizure condition is especially dangerous while he is asleep. Sleeping itself appears to induce more seizures, and it is harder to identify the appellant's seizures during sleep due to his positioning and the fact that he is not alert at the onset of the seizure. The seizure signals are much more subtle, and they require nearly constant observation to detect. [redacted] testified that it is critically important to intercept a seizure at the earliest possible moment. Though it is impossible to predict seizures, there are triggers. Certain environmental events can trigger seizures, and smaller seizures can trigger larger ones if not interrupted. The appellant can get caught in a cycle of seizures that is harder to interrupt.

The appellant's representatives acknowledged that non-nurses could be trained to identify the seizure signals, but a non-nurse would not be able to provide the required interventions. [redacted] testified that immediate response is not necessary. Depending on the type of seizure, the appropriate response is just more monitoring. However, deciding the appropriate response requires a clinical, nursing decision. The appellant often has small seizures that require no intervention. If the appellant's seizures are clustering, it is hard to identify when one begins and ends. If there is continuous seizure activity for more than 3 minutes, intervention of some kind is needed. Sometimes, this is medication, other times it is a change in his physical position. There is a hard stop of 10 minutes, however, where you would need medical intervention, as he is starting to risk brain damage.

The appellant's seizures started getting worse around 2019. The appellant would go to the hospital every time he had a significant seizure event and be admitted to the intensive care unit. [redacted] opined that the appellant is safer at home than in any hospital, even in the ICU, given an appropriate level of staffing to monitor his seizures. Partly, this is because the appellant's care team at home is better trained to identify his seizure symptoms. Even in the ICU, nurse staffing levels do not typically allow one-on-one nursing around the clock for a patient.

This appeal arises from the appellant's annual LTSS Needs Assessment, which was performed in person on October 30, 2024. The Needs Assessment is an in-person evaluation of the member and their care. [redacted] the appellant's Clinical Manager, performed the Needs Assessment. Also present were the member, the member's mother, and one of the member's other nurses.[2] The parties agreed that this Needs Assessment interview took place over several hours. Additionally, CCM reviewed documents, including the medication orders, the Home Health Certification and Plan of Care,[3] which includes doctors' orders, a seizure response plan created by [redacted] and nursing flow sheets and notes. CCM then determines the clearly identifiable, specific

[2] The appellant's mother is also one of his CCM-paid nurses.

[3] There are two Plans of Care in the record. The Home Health Certification Plan of Care includes orders for both nursing and personal care assistance. It was created September 18, 2024. (Exhibit 8, pp. 132-145.) An Independent Nursing Plan of Care was dated January 14, 2024, and it only addresses nursing interventions. (Exhibit 8, pp. 146-161.)

medical needs for CSN services and the time required to perform each nursing intervention. This time is catalogued in a chart that reflects the nursing time allotted in each body system category.[4]

This assessment was finalized through a letter dated January 30, 2025, which determined that the appellant should receive an increase from 109 hours per week of CSN services to 114 hours per week of CSN services. The assessment also authorized 27 hours per week of Personal Care Attendant ("PCA") services and 39.5 hours of Complex Care Assistant ("CCA") services per week. CCM also authorized an additional 5% of this time to cover administrative and documentation time. This equates to an additional 6 hours of CSN time per week, for a total of 120 CSN hours per week. Altogether, the appellant's services were increased to 186 hours and 30 minutes per week, starting February 2, 2025, through January 31, 2026.

The chart depicting the appellant's individualized assessment for skilled nursing needs is available in Exhibit 8, pages 94-101. This chart is divided into body systems, categories of nursing interventions within a body system. Specific tasks are detailed within each category of nursing intervention. The chart attempts to identify how frequently nursing interventions are needed and how long they take on average. The body systems included in the appellant's Needs Assessment are: "Respiratory"; "Cardiac/Autonomic Instability"; "Gastro-Intestinal (GI)/Nutrition"; "Genito-Urinary (GU)"; "Wound Care/Skin"; "Neurological"; "Pain Management"; "Musculoskeletal"; and "Other considerations in Skilled Care Needs."

Within the Respiratory body system, the appellant disagreed with the skilled nursing time allowed in intervention categories of: "Suction Type/frequency"; "O2 Desaturations frequency"; and "Skilled Assessment/respiratory."

Regarding **suctioning**, MassHealth's assessment states:

> Tracheal/oral suctioning is required an average of 30 times per day
>
> Five (5) times first thing in the morning, that require instillation of normal saline 3ml bullet in addition to multiple passes and assessment of airway clearance. Time allotted= 5 minutes per episode = 25 minutes per day.
>
> Fifteen (15) times throughout the day, 5 minutes for 10 episodes that require saline to thin secretions (50) and 3 minutes for 5 episodes that do not require saline, (15) = 65 minutes per day.
>
> Ten (10) times overnight that do not require saline, 3 minutes per episode= 30 minutes

[4] [redacted] explained that these hours are approved based upon medical need. Other insurances would be billed first, but other insurance would not be an alternative source of additional services beyond the hours authorized by MassHealth.

Total time allotted 25 + 65 + 30 = 120 minutes per day including respiratory assessment and any additional suction during treatment

(Exhibit 8, p. 94.)

MassHealth's representative explained that the appellant is approved for more than 2 hours of nursing care for suctioning each day, because additional suctioning also happens during other nursing interventions. The appellant is suctioned, on average, an additional 30 times per day unrelated to other nursing interventions. This time is broken down according to the suctioning tasks described by the appellant's care team at the Needs Assessment. Usually, suctioning only takes 3 minutes, but other times the appellant's secretions need to be thinned with saline. In the morning, the appellant was described as being suctioned 5 times, and because his secretions need to be thinned with saline, he is allowed 5 minutes per suctioning, for a total of 25 minutes.

The appellant's mother specifically felt the morning suctioning time was insufficient due to the additional complexity involved with waking him up. The appellant is at a higher risk for seizures while he sleeps. The appellant's mother testified that the appellant needs to be woken up gently so as to avoid triggering a myoclonic seizure. The appellant's mother also tries to get the appellant used to the sound of the suctioning machine before suctioning starts. The appellant has a tracheostomy, and he uses a ventilator overnight. In the morning, the appellant switches over from the ventilator to an oxygen mask. It is during this change over that the appellant requires suctioning.

The appellant also has thicker secretions in the morning because he has been laying down. Suctioning thoroughly requires thinning the mucus and taking several passes to fully clear. The appellant's mother argued that it is different every day, but right now environmental allergies make the morning respiratory regime take longer. The appellant's mother's nursing notes reflect that each suctioning takes an average of 6 minutes, without the additional time needed to thin the appellant's mucus with saline. She had not checked the nursing notes for how long other nurses take. The appellant's mother agreed with the frequency of suctioning events, but she requested 10 minutes instead of 5 minutes per morning suctioning, partially to allow time for acclimating the appellant to the sound of the suctioning machine.

MassHealth's representatives responded that the time allotted for suctioning was an average that was meant to capture both times that take longer than expected and times that take less time than expected. She also testified that there are many other instances where suctioning is an included component of the care being provided. For instance, nebulizer treatments, chest physiotherapy, and the cough assist device all include time for suctioning.

Regarding the time needed to acclimate the appellant to the sound of the suctioning machine, MassHealth's representative testified that time is approved based upon active nursing interventions. Acclimating the appellant to the sound may be medically necessary, but it does not require the skills of a nurse. A PCA or CCA could be responsible for this additional time. The

appellant's attorney objected to the reality of having a PCA scheduled to come in just to turn on a machine. MassHealth's representative explained that the program authorizes blocks of time based upon needed nursing interventions but leaves it up to consumers and their care team to utilize that time as they see fit. MassHealth's representatives acknowledged that there will be non-compensated tasks that a nurse will do during their shift because the tasks need to be done, and the nurse is there. MassHealth's representatives also explained that their average times usually err on the side of the member because the CCM nurse-reviewers know task times come in a range. The appellant's mother did not believe that 5 minutes per suctioning was erring on the side of the member with regards to how long suctioning takes. The appellant's mother argued that the appellant's care cannot be captured in a rigid review system like this, and that more nursing assistance is needed.

MassHealth's representative noted that the appellant is approved for over 180 hours of care per week, including assistance from PCAs and CCAs. This is more than 24 hours of care per day. MassHealth's representatives explained that a CCA is hired by nursing agencies and receives additional training from the nursing agencies in how to assist with complex patients. PCAs are hired by the consumer and trained by the consumer. MassHealth's representative testified that a PCA can be trained to provide suctioning, though the appellant's mother strenuously objected to the idea of a PCA providing suctioning. The appellant's mother felt PCAs and CCAs were unhelpful when directly caring for the appellant, and she generally only utilized them for chore assistance. The appellant's mother does not feel a PCA or CCA is helpful because they still require supervision, which means she still needs to be on hand to respond even if a PCA or CCA is caring for the appellant.

Another area of contention was time allowed for responding to **oxygen ("02") desaturation**. The Needs Assessment recorded:

> Baseline oxygen saturation (O2 sat) is 93% on room air. Oxygen levels are spot checked hourly (12 times) during the day and continuously overnight. Time allotted is 3 minutes each time = 36 minutes per day. Time includes visual assessment of skin color and nail beds/lips for cyanosis.
>
> Time allotted to rotate probe site every 2 hours overnight is 3 minutes 6 times per night = 18 minutes per day.
>
> Oxygen desaturations are reported 5 times per day. Interventions include respiratory and neurologic assessments, repositioning, and if level is below 88%, O2 administration/titration. Time allotted to manage desaturations, assess lung sounds and ensure return to baseline is 15 minutes per episode = 75 minutes per day.
>
> Total time allotted in this section is 36 + 18 + 75 = 129 minutes per day to include respiratory assessment.
>
> Additional time allotted in neurological/seizure section.

(Exhibit 8, p. 95.)

MassHealth allowed 75 minutes per day to allow 5 responses to oxygen desaturation, at 15 minutes per response. The appellant's attorney identified several nursing notes that described weaning the appellant off of O2 and argued that the average time to wean the appellant off of O2 was 25 minutes. (Exhibit 8, p. 265.) Therefore, the appellant requested 25 minutes per desaturation response instead of 15.

Nursing logs for September 23, 2024, through October 11, 2024, are in the record at Exhibit 8, pp. 265-266. Across these 18 days, nursing notes appeared for only 13 days. Across the 13 days with notes, 12 events involving O2 are logged occurring on 9 separate days. Of the 12 events, 5 describe the duration of the response, ranging from 20 to 30 minutes. The remaining 7 events simply note that the appellant "remained on O2." There are 3 days involving 2 desaturation notes, so half of the 12 events occurred on 3 days.[5] Out of 13 days with notes, 4 days reflect no desaturation events.

The appellant's mother testified that the morning transition from the ventilator to room air is the most regular and time-consuming O2 desaturation event. Before the appellant can take oral medications, he needs to be taken off the ventilator and the trach needs to be capped. The appellant's mother explained that the process involves removing the ventilator, which has a tight seal, and attaching a trach collar, which allows some room air to mix with the O2. The trach collar has a compressor that also needs to be turned on. The trach collar provides some supplemental O2, just not as much as the ventilator. The nurses assess his pulse oximetry, assess his appearance to make sure his lips or fingernails do not turn blue, and also watch for any other visual signs of desaturation. The nurses are also changing up humidification at this time. The appellant receives warm humidification overnight and cool humidification during the day. If the appellant remains stable, they sit him up, moisten his nasal airways, and then cap the tracheostomy. The process takes 30-45 minutes, and the appellant can have multiple O2 desaturation warning signs within that single transitioning process.

The appellant can have additional O2 desaturations throughout the day. The appellant's mother testified that Pitt Hopkins syndrome creates a variety of respiratory issues including shallow lungs and uneven breathing. O2 desaturations can take on different forms or appearances. At baseline, the appellant's O2 is only at 93%. If he is tired it can be in the 80s. A lot of his medications impede his breathing. Sometimes these complications clear up on their own, but the appellant's mother testified that she usually starts preparing supplemental O2 through the trach collar while observing to see if the appellant is desaturating. The appellant can also choose to hold his breath for up to 10 minutes, and it is difficult to understand if this is something he is choosing to do or the result of a medical event. The appellant's mother acknowledged that other O2 interventions could take as

[5] It is possible that these days involving 2 desaturation notes actually refer to the same event and are recorded by nurses as hand-off documentation. This would mean there were only 6 days out of 13 with desaturation events, and no days with multiple desaturation events.

little as 10 minutes, but every situation is different. The appellant's mother testified the maximum number of O2 desaturations throughout the day would be 5.

The appellant's mother explained the process for responding to an O2 desaturation event. The appellant is brought into another room where they keep his oxygen equipment. This equipment includes a compressor and oxygen tank. The trach cap is removed, and the trach mask is attached to provide supplemental O2. The appellant's mother testified that the set-up time is about 10 minutes, and the O2 is pushed for 10 minutes.

MassHealth's representatives noted that there are 10 minutes, twice per day, allowed for transitioning off of and onto the ventilator. This time is included in a total of 92 minutes per day allowed for "Mechanical Ventilation Care Management (CPAP, BIPAP, Ventilator)," though most of this time involves managing the ventilator overnight:

> Use of the ventilator (vent) is required for 12 hours overnight with 8 liters of Oxygen. Member is changed from vent to trach mask and back 2 times per day. Time allotted is 10 minutes each time to include applying the vent, checking the vent settings, assessing tolerance, instillation of saline into nares, suctioning, monitoring and titrating oxygen to maintain level >93 and assessment of nail beds, lips for cyanosis, skin color and respiratory status. Time allotted 20 minutes per day. Additional time allotted hourly during use for assessing the integrity of the vent to trach connection and reconnecting the vent tubing as needed, humidification management, emptying water traps and responding to all alarms is 5 minutes per hour or 60 minutes a day. Time allotted to change the filters and circuits on vent every 2 weeks is 20 minutes (divided by 14 days) is 2 minutes a day averaged. Total time allotted in this section is 10 + 60 +20 + 2 = 92 minutes a day.

(Exhibit 8, pp. 94-95.)

"Skilled Assessment/respiratory" was the final disputed intervention within the Respiratory body system. The Needs Assessment allows no time, stating: "Time allotted for respiratory assessment is included in skilled care." (Exhibit 8, p. 96.) MassHealth does not believe additional assessment time is appropriate in respiratory care because the appellant is constantly assessed whenever he is receiving nursing interventions. The appellant's response is that, because MassHealth has not approved 24-hour nursing interventions, there remains a window of time during which nursing assessments are required but are not being provided.

In addition to assessment time built into other tasks throughout the day, MassHealth's representatives noted circumstances where additional time for assessment was approved. Hourly pulse oximetry is taken during the day (12 times), and the appellant is connected to a continuous monitor overnight. The monitor probe location is changed every 2 hours overnight (6 times). Each of these interventions is allowed 3 minutes and is intended to include "visual assessment of skin

color and nail beds/lips for cyanosis." (Exhibit 8, p. 95.) The Home Health Plan of Care includes orders for overnight pulse oximetry, but the Plan of Care does not identify specific schedules for daytime assessment. (See Exhibit 8, pp. 140-141.) The Independent Nursing Plan of Care includes general guidelines for managing care, but it does not detail specific schedules for providing assessments. (See Exhibit 8, pp. 151-152.)

Twenty minutes per day is also allowed for "[v]ital signs including temperature, heart rate (HR), blood pressure, respiratory rate and pain assessment, monitored 4 times per day. Time allotted is 5 minutes each time … ." (Exhibit 8, p. 96.) Thirty minutes per day is allowed for "Seizures frequency," "including neurological assessment." (Exhibit 8, p. 98.) There is also 30 minutes per day allowed "for general systems assessment, including GI, pain, and Musculoskeletal assessment," under the category of "Other considerations in Skilled Care Needs." (Exhibit 8, p. 99.)

The appellant's representatives reiterated that the appellant requires constant assessment. There are a variety of circumstances and situations in which the appellant is unable to communicate his need for suctioning, or where a nurse needs to identify what he needs. The seizure response plan requires intervention within 5 minutes, which means that someone has to assess him for seizures at least every 5 minutes. The appellant's representatives acknowledged that their ultimate goal is to have 24 hours per day of CSN, or 168 hours per week. The appellant requested 14 minutes per hour be allowed in the "Skilled Assessment/respiratory" category, but this number was partly decided upon based upon trying to fit 24 hours of care within the Needs Assessment rubric.

The appellant initially raised concerns regarding how MassHealth determined time for responding to the appellant's autonomic storms. Regarding the body system "Cardiac/Autonomic Instability," MassHealth allowed 20 minutes per day for vital signs, including "temperature, heart rate (HR), blood pressure, respiratory rate and pain assessment." (Exhibit 8, p. 96.) Each assessment was allowed for 5 minutes, and it was scheduled 4 times per day. The appellant's representatives testified that they were seeking 28 minutes per day to take into consideration the cardiac component of his autonomic storms.

The appellant's mother argued that the time for assessing autonomic instability was vastly insufficient. She testified that the appellant has autonomic storming events that can last 10 hours at a time. The appellant's mother described these events as neurological, cardiac, and respiratory crises combined. The appellant can have an elevated heartrate, sweating, elevated temperature, and O2 desaturations. These events require constant attention from a nurse. MassHealth's representative explained that the time in "Cardiac/Autonomic Instability" was for daily vital checks, but there was an additional 18 minutes per day given for "Skilled assessment needs related to fluctuation in Medical status" within "Other considerations in Skilled Care Needs":

> Autonomic Storming: [the appellant] experiences "storming" episodes every 7-10 days that last an average of 10 hours. During these events, his temperature rises and HR becomes elevated (120-150 beats per minute), hyperdiaphoresis of body requiring body cooling interventions such as fluids,

> cool compresses and fans. Hypertension and O2 desaturations below 90% occur. Interventions required until symptoms resolve and include Clonazepam administration at onset if responsive (may repeat in 6 hours; Nidazolam if unresponsive), temperature checks, O2 saturations and HR and BP checks every 30 minutes, oxygen with titration for desats, Motrin/Tylenol as needed and cooling measures. Time averaged to 18 minutes per day.

(Exhibit 8, p. 100.)

MassHealth's representative explained that 18 minutes is allowed per day, because these events occur irregularly. MassHealth allowed 5 minutes, 20 times per storm, which would be 5 minutes every 30 minutes for 10 hours. MassHealth also allowed 5 minutes for Clonazepam administration, once per storm. Three minutes, twice per storm for Tylenol or ibuprofen. Cooling measures were allowed at 5 minutes, twice per storm. The appellant's care team had reported a storm occurring every 7-10 days, so MassHealth allowed 121 minutes of care every 7 days, which totaled 17.24 minutes per day. This was rounded up to 18 minutes. (See Exhibit 8, p. 116.) MassHealth's representative also noted that this was additional nursing time. During these episodes, the time approved for other nursing tasks would stay approved, even though the nurses might not be able to perform those tasks. The appellant's representatives acknowledged that during these storms there is nothing that can be done except respond to symptoms, monitor, and assess. Once the math was explained, the appellant accepted this method of calculating time for autonomic storms.

The next disputed body system was "Gastro-Intestinal (GI)/Nutrition," within which the appellant disputed the time allowed for "**Oral feeds**."

> [The appellant] drinks 8-10 (10oz) glasses of honey thick liquids per day with a straw. Four (4) tablespoons of Thick-it are mixed with fluids to create honey thick consistency. Trach cap is in place during feedings. Time allotted to mix Thick-it with fluids and maintain aspiration precautions/monitor for aspiration is 5 minutes each time = 50 minutes per day.
>
> In addition to Gastrostomy-tube (G-tube) feeds, [the appellant] eats 3 meals and 2 snacks of textured puree food by mouth daily. Time allotted per meal is 10 minutes = 30 minutes per day; and time allotted per snack is 5 minutes = 10 minutes per day.
>
> Time for the act of feeding and checking for pocketing allotted on PCA evaluation.
>
> Total time allotted in this section is 50 + 30 + 10 = 90 minutes per day including time to assessment/ monitor for signs/symptoms of aspiration.

(Exhibit 8, p. 96.)

The appellant's mother testified that it takes 20 minutes, not 10 minutes to feed the appellant. She testified that it takes 10 minutes to mix the food and 10 minutes to feed him. She did not want a PCA involved in feeding the appellant because they do not mix the food well, despite multiple trainings. The appellant's mother acknowledged that she, or a nurse, can check the consistency of the food and correct it if it is mixed by a PCA. This only takes a minute of time, but she does not find it helpful because she still needs to be present to check the PCAs work. MassHealth's position was that there is time for nursing and PCA services associated with feeding, and they can work in conjunction with each other.

The PCA evaluation authorized PCA time for "Breakfast- 15 min, Lunch-20 min, Dinner- 30 min… and 2 snacks (10 min each) by mouth daily. He drinks honey thick fluids from a cup. 5 additional minutes allotted to each feeding for preparation and pureeing of food." (Exhibit 8, p. 107.)

The next body system is "Genito-Urinary (GU)," and the care category is "**Catheter care/frequency**." The Needs Assessment allows "Urine dipsticks to monitor nitrates are performed every morning. Time allotted is 2 minutes per day." (Exhibit 8, p. 97.) Time is also allotted under "Skilled assessment/GU" at "10 minutes per day to assess penile skin integrity and to assess urethral discharge, amount, color, odor of urine and signs of irritation or infection. [The appellant] requires Calmoseptine cream application for redness and irritation applied an average of 3 times per week." (Exhibit 8, p. 98.)

The appellant argues that catheter care is inappropriate for a PCA or CCA to perform. The appellant's mother explained that the appellant wears a condom catheter, and it must be taped onto the shaft of his penis. The appellant often rips the catheter off and tears his skin in the process. The appellant's mother testified that she does not trust a PCA to do this task because they have taped the catheter to his scrotum or taped it too tightly in the past. She has repeatedly trained PCAs on how to do it, but she is no longer comfortable with their attempting the task. The appellant is requesting 5 minutes per day for a nurse to apply the catheter instead of a PCA.

Both Plans of Care identify the appellant's need for "Personal Care" including: "bathing, dressing, diapering, skin and oral care." (Exhibit 8, pp. 136, 149.) The PCA authorization regarding Bladder Care states the appellant "is dependent for adult brief changes for bladder care 6x/day on average. Includes transfers as needed, thorough cleansing, brief change, and clothing management." (Exhibit 8, p. 107.) The Plans of Care also identifies "TREATMENTS: --SKILLED NURSING-- - Urinary Catheter Condom catheter to be used PRN at parental discretion to reduce exposure to groin/buttocks moisture. Change daily when in use." (Exhibit 8, pp. 142, 153.)

Within "**Wound Care/Skin**," the two interventions within the body system were "Wound Care frequency" and "Skilled assessment/Skin." For Wound Care, the Needs Assessment states: "Pinpoint open area on coccyx applying damp textured gauze to cover area to assist in debridement. Area measured and recorded daily. Time allotted is 5 minutes daily." (Exhibit 8, p. 98.) Regarding assessment:

> [The appellant] is prone to skin breakdown due to immobility. He has chronic/recurrent diaper rashes and cysts in his groin area, scrotum. Calmoseptine, zinc oxide and Nystatin powder are applied to the affected skin and a dressing may be used to cover the cysts if needed. Frequent repositioning is required. Time allotted for skilled skin assessment is 5 minutes 3 times per day = 15 minutes per day. Time includes assessment, determining which of his multiple prescribed creams to apply.

(Exhibit 8, p. 98.)

The appellant's representatives argued that 20 more minutes per day are needed for wound care and 10 more minutes per day are needed for assessment. The appellant's mother testified that they clean, assess, and maintain every time they do peri-care. The PCA evaluation states that peri-care is performed 6 times per day. (Exhibit 8, p. 107.) The appellant's mother testified that the appellant gets cysts on his chest around the contact points for the trach tubing. If a nurse identifies a cyst early, its development can be prevented through warm compresses and Calmoseptine several times per day. If the cysts are not caught early, they can develop into painful nodules that need to be surgically removed. The appellant's mother also testified that additional wound care is needed when the appellant injures himself removing his catheter. MassHealth's general response was that time was allowed for catheter care for assessing penile skin integrity and applying creams 3 times a week. PCA time does not appear to be approved for lotion or skin care, but it is described as a personal care task in the Home Health Plan of Care. (See Exhibit 8, pp. 105, 136, 138.)

Within the "Neurological" body system, the Needs Assessment included no time for "**Skilled assessment/neurological**":

> Time allotted for skilled neurological assessment is included with seizure management. In addition to seizure disorder, [the appellant] experiences autonomic storming and thermoregulation issues which requires additional interventions cooling, air conditioner/fan, Tylenol, cold compresses, temperature checks and assessing need for and response to PRN medications. He receives daily doses of Propanolol and Clonidine to help manage storming. Time allotted to manage storming episodes is included the in Other Considerations in Skilled Care Needs section.

(Exhibit 8, p. 99.)

The appellant understood how MassHealth was allowing time for autonomic storming, described above. However, the appellant continued to argue that 24-hour care was necessary to ensure there was a nurse available to assess the appellant for seizures at all times.

Within the "Musculoskeletal" body system, the appellant requested time for range of motion exercises and time to place the appellant in a stander for partial weight-bearing. No time had been

allotted under this body system. MassHealth's representatives testified that the appellant was approved for **passive range of motion** ("PROM") assistance for a PCA to provide, and that this task is typically not a skilled task. They accepted that it could be a skilled task if the appellant had a dislocation or osteopenia (brittle bones). The PCA assessment states "Passive range of motion (PROM) performed to upper [and lower] extremities twice daily, due to limited volitional movement, and to prevent contractures. Per [appellant's mother's] report, nursing does not perform PROM." (Exhibit 8, p. 106.) The appellant's mother did not recall reporting that. The appellant is approved for a total of 60 minutes per day for a PCA to perform PROM.

The appellant's mother agreed that the appellant does not have dislocations, but she testified that he did have hypotonia and mild osteopenia. The Home Health Plan of Care notes "CCA TO ASSIST WITH THE FOLLOWING CARE: … Mobility … -Provide passive ROM all 4 extremities." (Exhibit 8, p. 138.) However, it also orders "TREATMENTS: --SKILLED NURSING-- - ROM (Range of Motion) Nurse to perform PROM to upper extremities every shift for each extremity, only to resistance, and as tolerated by patient. Nurse to perform PROM to lower extremities every shift for each extremity, only to resistance, and as tolerated by patient." (Exhibit 8, pp. 143.) This order is repeated in the Independent Nursing Plan of Care. (Exhibit 8, p. 153.) Both Plans of Care identify the appellant as having "Impaired Musculoskeletal Status." The nursing notes also reflect that PROM is being performed by nurses. (Exhibit 8, pp. 285, 411.)

Regarding the **stander**, the appellant's mother testified that she uses the Sara lift that the appellant uses for transfers, and she allows the appellant to bear some weight in the lift to help develop muscles. The appellant's mother testified that she tries to make it fun for the appellant, so she will dance with him and do more than simply have him partially weight bear for 5 minutes at a time. The appellant requested 25 minutes per day for partial weight bearing.

MassHealth's representative argued that if the PCA is able to transfer the appellant using the Sara lift, then it is functionally the same practice to using it as a stander. The PCA authorization for mobility mentions that the appellant "can sometimes stand for 2-3 minutes at a time," but does not explicitly authorize time for using a stander. (Exhibit 8, p. 103.) There is no mention of a stander in either Plan of Care. The list of durable medical equipment lists a "Rifton Gait Trainor" as a stander and states the appellant has "one at home and one at school." (Exhibit 8, p. 90.)

The appellant's representatives reiterated their position that the appellant requires 24-hour nursing care. MassHealth's representative responded that all CCM members require 24-hour supervision from someone who is able to provide the required interventions. A requirement for participating in the CCM program is that there be a trained caregiver responsible for managing the member's medical needs. MassHealth's representatives confirmed that there is no upper cap for nursing hours but explained that nursing hours were approved based upon identifiable nursing interventions. The number of nursing hours is based solely upon how many specifically identifiable nursing services must be performed on behalf of the member in an average day. As discussed, there are a variety of ways MassHealth takes into consideration the fact that no CCM-member is

average. MassHealth's representative acknowledged that the realities of scheduling nurses will result in skilled interventions being required at a time when nursing staff is not scheduled.

MassHealth's representatives also acknowledged [redacted] position that the appellant needs to be assessed around the clock for seizures. These assessments are to determine whether the appellant is having a seizure. MassHealth considers assessments when the appellant is not having a seizure to be "anticipatory." MassHealth argues that anticipatory care is not covered because no skilled intervention results from an assessment that does not find intervention is needed. MassHealth also argues that identifying the seizure is not necessarily skilled, though they accept that responding to the seizure is skilled. Where staffing gaps result from this, MassHealth's position is that it is incumbent upon the responsible caregiver to be able to respond to those situations.[6]

The appellant's mother testified that she has no opportunities for down time because of this system. She and her ex-spouse theoretically have shared custody, but the appellant cannot go to the ex-spouse's home. The ex-spouse is also unable to provide skilled care to the appellant, so during his visitation rights, the appellant's mother needs to be on hand. MassHealth's representative testified that "respite" care exists both through CCM and through the Department of Developmental Services. CCM's method for providing respite time generally involves nursing facility care. The appellant's mother was adamant that she would not allow the appellant to go into a facility for any period of time because she did not trust the quality of care the appellant would receive there. MassHealth's representatives said that the appellant's mother could reach out to DDS regarding additional nursing services to allow respite care through their program. Moving forward, if the appellant feels there is an error with the Needs Assessment, or if there is a change to the appellant's care, MassHealth's representatives explained that the appellant may request an adjustment to the Needs Assessment. This adjustment request must identify the specific change of care that requires adjustment and provide clinical documentation for that change.

Findings of Fact

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

1) The appellant is a young adult who enrolled with CCM on February 2, 2022. (Testimony by MassHealth's representative.)

[6] The appellant's mother's argued that her dual-role as both MassHealth-compensated nurse and responsible caregiver puts her in an unfair position of being able to provide more care than the typical family caregiver. MassHealth's representatives again noted that hours are approved based upon the amount of documented, compensable nursing services. This review does not reduce hours because the appellant's mother happens to also be a nurse, or because the appellant's mother happens to cover several of the appellant's nursing shifts.

2) The appellant's two primary diagnoses are Lennox-Gastaut Syndrome, a severe seizure disorder, and Pitt Hopkins syndrome, a genetic condition that significantly impacts his respiratory system. The appellant has other complicating diagnoses as well. (Exhibit 8, p. 79; testimony by [redacted] and the appellant's mother.)

3) On October 30, 2024, MassHealth's CCM program began the appellant's annual LTSS Needs Assessment. [redacted] the appellant's Clinical Manager, met for several hours with the member, the member's mother, and one of the member's other nurses. (Testimony by MassHealth's and the appellant's representatives.)

4) On January 30, 2025, MassHealth mailed out a letter finalizing this Needs Assessment, and allowing 120 CSN hours per week, including 6 hours of administrative and documentation time. Also approved were 27 hours per week of PCA services and 39.5 hours per week of CCA services. This authorization runs from February 2, 2025, through January 31, 2026. (Exhibit 8, pp. 119-121.)

5) The appellant had previously been approved for 109 hours of CSN services per week. (Testimony by MassHealth's representative.)

6) MassHealth detailed how it arrived at its calculated time in the Needs Assessment, and the appellant accepted most of the decisions made by MassHealth. (Exhibit 8, pp. 94-116; testimony by the appellant's representatives.)

7) The appellant initially questioned how MassHealth calculated time for responding to an autonomic storm. Once the process for authorizing time for intermittent interventions was reviewed, the appellant accepted MassHealth's decision to allow 18 minutes per day to respond to autonomic storms that lasted 10 hours but occurred every 7 days. (Exhibit 8, pp. 99, 100, 116; testimony by MassHealth's and the appellant's representatives.)

8) The appellant disputed MassHealth's determination of medical necessity for the following:

9) **Respiratory – Suctioning in the morning**:

    a. MassHealth allowed 5 episodes of suctioning in the morning at 5 minutes per episode; 2 extra minutes per episode were included because saline was needed to thin the appellant's mucus. (Exhibit 8, p. 94.)

    b. The appellant requested 10 minutes per episode of suctioning in part because the appellant's mother believes 5 minutes is insufficient time per suctioning. (Testimony by the appellant's representatives.)

    c. The appellant also requested this increase to allow time for a nurse to turn on the suctioning machine for 10 minutes before the appellant's ventilator is removed. The appellant is at higher risk of seizures when he is sleeping and waking up.

Environmental stimuli can trigger seizures for the appellant. (Testimony by the appellant's mother and [redacted])

d. Turning on the suctioning machine is not a skilled task. (Testimony by MassHealth's representative.)

10) **Respiratory – O2 desaturation**:

a. MassHealth allowed 75 minutes per day to allow 5 responses to oxygen desaturation throughout the day, at 15 minutes per response. (Exhibit 8, p. 95.)

b. When transitioning from the ventilator to room air, the appellant is at high risk for O2 desaturation. There are several steps in the transition process, during which the appellant's O2 may drop, and supplemental O2 may be required. On average, the whole process takes 30-45 minutes. (Testimony by the appellant's mother.)

c. It is difficult to assess when the appellant is suffering O2 desaturation. If the appellant's nurse believes that his O2 is dropping, they will begin the process of reconnecting his trach mask to start providing supplemental O2. This involves bringing the appellant to another room, turning on the O2 compressor, removing the trach cap, and reattaching the trach mask. The appellant can have up to 5 such interventions per day. Sometimes the interventions can be stopped because no desaturation event is happening. (Testimony by the appellant's mother.)

d. Nursing notes from September 23, 2024, through October 11, 2024, include 5 notes that record supplemental O2 being provided for 20 to 30 minutes. There are 12 nursing notes documenting supplement O2 across this 18-day period. (Exhibit 8, pp. 265-266.)

11) **Respiratory – Skilled Assessment**

a. MassHealth allowed no separate time for assessing the appellant's respiratory system. MassHealth considers assessment time to be included in skilled care that was authorized. This includes hourly pulse oximetry checks during the day, and pulse oximetry probe relocations every 2 hours over night. (Exhibit 8, pp. 95-96; testimony by MassHealth's representatives.)

b. The appellant requested 14 minutes per hour to assess the appellant's respiratory status in addition to the other time authorized. The appellant argues the time is needed because the appellant's respiratory status must be constantly assessed. (Testimony by the appellant's representatives.)

c. The Plans of Care do not include orders regarding respiratory assessment frequency. (Exhibit 8, pp. 140-141; 151-152.)

12) **Gastro-Intestinal (GI)/Nutrition – Oral Feeds**

a. MassHealth allowed 10 minutes, 3 times per day for meals, and 5 minutes, twice a day for snacks. The Needs Assessment notes that "the act of feeding and checking for pocketing" is a PCA task. The Needs Assessment does not specifically describe what task the nurse is performing with this time. (Exhibit 8, p. 96.)

b. MassHealth allowed 85 minutes per day for a PCA to feed the appellant and check for pocketing. Additional time was authorized for preparation of food. (Exhibit 8, p. 107.)

c. The appellant requested 10 extra minutes per meal for a nurse to feed the appellant. The appellant's mother argues that all of the feeding should be a nursing task because a nurse needs to supervise the PCA's performance. (Testimony by the appellant's mother.)

13) **Genito-Urinary (GU) - Catheter care**

a. MassHealth allowed 12 minutes per day to assess the appellant's penile skin integrity and to assess urethral discharge. (Exhibit 8, pp. 97-98.)

b. Applying a condom catheter is typically an unskilled task. (Testimony by MassHealth's representative.)

c. The appellant removes the condom catheter and harms himself if it is not appropriately applied. This creates additional skin integrity assessment and care. (Testimony by the appellant's mother.)

d. The Plans of Care identify catheter care as being a skilled nursing intervention. (Exhibit 8, pp. 142, 153.)

e. PCA time is authorized for diapering/briefs, it is not authorized for catheter care. The Plans of Care do not describe catheter care as being a PCA task. (Exhibit 8, pp. 107, 136, 149.)

14) **Wound Care/Skin – Frequency**

a. MassHealth allowed 5 minutes daily for "applying damp textured gauze to cover area to assist in debridement. Area measured and recorded daily." (Exhibit 8, p. 98.)

b. The appellant's mother testified that, given the location of this pinprick wound in the appellant's peri-area, they provide additional wound care every time they provide peri-care. The appellant requested 20 extra minutes per day for additional wound care for this reason. (Testimony by the appellant's mother.)

c. PCA time is authorized for 6 instances of peri-care per day. (Exhibit 8, p. 107.)

15) **Wound Care/Skin – Assessment**

a. MassHealth allowed 5 minutes, 3 times per day for skin assessments related to cysts to determine appropriate creams to be applied. (Exhibit 8, p. 98.)

b. The appellant requested 10 minutes per day to allow a nurse to address cysts as they develop. This would involve applying warm compresses and over-the-counter ointments several times per day to the cysts. (Testimony by the appellant's mother.)

c. Skin is described as a personal care task in the Home Health Plan of Care. (See Exhibit 8, pp. 105, 136, 138.)

16) **Neurological – Skilled assessment**

a. MassHealth only allowed time for neurological assessments when needed to respond to an autonomic storm. Otherwise, MassHealth considered the neurological assessments to be included in the other skilled care authorized. (Exhibit 8, pp. 99, 116; testimony by MassHealth's representatives.)

b. The appellant argues that neurological checks must occur every 5 minutes, because seizures have to be interrupted within 5 minutes. (Testimony by the appellant's representatives.)

c. A clinical response is needed if a seizure continues for 5 minutes. Assessing whether the appellant is having a seizure does not need to be performed by a nurse. (Testimony by [redacted].)

17) **Musculoskeletal – PROM**

a. MassHealth authorized 60 minutes per day for a PCA to perform PROM. PROM is generally not a skilled task, though it can be if the member has musculoskeletal impairments such as dislocation or osteopenia. (Exhibit 8, p. 106; testimony by MassHealth's representative.)

b. MassHealth authorized this as PCA time in part because the appellant's mother reported that "nursing does not perform PROM." (Exhibit 8, p. 106; testimony by MassHealth's representative.)

c. The appellant's mother does not recall reporting that nursing does not perform PROM, and she does not believe a PCA could safely perform the PROM exercises. The appellant does have musculoskeletal instabilities in the form of hypotonia and

mild osteopenia, though the osteopenia is not documented in the appellant's current clinical record. (Testimony by the appellant's mother.)

d. The Home Health Plan of Care identifies PROM as both a CCA task and as a skilled nursing treatment. (Exhibit 8, pp. 138, 143.)

e. The Independent Nursing Plan of Care identifies PROM as a nursing intervention. (Exhibit 8, p. 153.)

f. The submitted nursing notes reflect that nurses perform PROM. (Exhibit 8, pp. 285, 411.)

18) **Musculoskeletal – Stander**

a. MassHealth authorized no time for using a stander. The PCA authorization for mobility mentions that the appellant "can sometimes stand for 2-3 minutes at a time," in the context of describing transferring assistance. (Exhibit 8, p. 103.)

b. The appellant's mother uses the Sara lift to allow the appellant to partially weight bear for a few minutes a couple times a day. The appellant requests 25 minutes per day to allow a nurse to place the appellant into a partial weightbearing position in the Sara lift. (Testimony by the appellant's mother.)

c. Using a Sara lift is not a skilled task, and placing a patient into a stander is not a skilled task. (Testimony by MassHealth's representative.)

Analysis and Conclusions of Law

MassHealth's regulations at 130 CMR 438.000 et seq. set forth the requirements for the payment of continuous skilled nursing ("CSN") services and complex care assistant services provided by a CSN agency. "Nursing services" are defined as "the assessment, planning, intervention, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of school of nursing approved by a board of registration in nursing. Such services include only those services that require the skills of a nurse." (130 CMR 438.402.)

All CSN agencies participating in MassHealth must comply with MassHealth regulations including, but not limited to, 130 CMR 438.000 and 130 CMR 450.000. (130 CMR 438.401.) These services are only authorized through prior authorization, and "MassHealth members and/or primary natural caregivers … determine when authorized CSN hours … [are] used in order to best support the member's needs. This can include scheduling authorized service hours in increments of less than two hours in order to meet the member's needs and best utilize authorized hours." (130 CMR 438.411, (G).)

Pursuant to 130 CMR 438.414, MassHealth or its designee provides administrative care management to complex care members that includes service coordination with CSN agencies as appropriate. This is to ensure that a complex care member is provided with a coordinated Long-term Services and Supports ("LTSS")[7] package that meets the member's individual needs and to ensure that MassHealth pays for nursing, complex care assistant services, and other community LTSS only if medically necessary in accordance with 130 CMR 450.204: *Medical Necessity*. (130 CMR 438.414.)

The Administrative Care Management regulations are:

> (A) Care Management Activities.
>
> (1) Enrollment. The MassHealth agency or its designee automatically assigns a clinical manager to members who may require a nurse visit of more than two continuous hours of nursing and informs such members of the name, telephone number, and role of the assigned clinical manager.
>
> (2) LTSS Needs Assessment. The clinical manager performs an in-person visit with the member, to evaluate whether the member meets the criteria to be a complex-care member as described in 130 CMR 438.402 and 438.410(B). If the member is determined to meet the criteria as a complex-care member, the clinical manager will complete a LTSS Needs Assessment. The LTSS Needs Assessment will include input from the member, the member's caregiver, if applicable, LTSS providers, and other treating clinicians. The LTSS Needs Assessment will identify (a) skilled and unskilled care needs within a 24-hour period; (b) current medications the member is receiving; (c) durable medical equipment currently available to the member; (d) services the member is currently receiving in the home and in the community; and (e) any other case management activities in which the member participates.
>
> (3) Service Record. The clinical manager:
>
> (a) develops a service record, in consultation with the member, the member's primary caregiver, and where appropriate, the CSN agency and the member's physician or ordering non-physician practitioner, that
>
> 1. lists those LTSS services that are medically necessary, covered by MassHealth, and required by the member to remain safely in the community, and to be authorized by the clinical manager;

[7] Long-term Services and Supports (LTSS) is defined in 130 CMR 438.402 as "certain MassHealth-covered services intended to enable a member to remain in the community. Such services include, but are not limited to, home health, durable medical equipment (DME), oxygen and respiratory equipment, personal care attendant (PCA), and other health-related services as determined by the MassHealth agency or its designee."

2. describes the scope and duration of each service;

3. lists other sources of payment (e.g. TPL, Medicare, DDS, AFC); and

4. informs the member of his or her right to a hearing, as described in 130 CMR 438.414.

(b) provides the member with copies of

1. the service record, one copy of which the member or the member's primary caregiver is requested to sign and return to the clinical manager. On the copy being returned, the member or the member's primary caregiver should indicate whether he or she accepts or rejects each service as offered and that he or she has been notified of the right to appeal and provided an appeal form; and

2. the LTSS Needs Assessment.

(c) provides information to the CSN agency about services authorized in the service record that are applicable to the CSN agency.

(4) Service Authorizations. MassHealth or its designee **will authorize those LTSS in the service record, including nursing, that require prior authorization and that are medically necessary, as provided in 130 CMR 438.413,** and coordinate all nursing services, any applicable home health agency services, and any subsequent changes with the CSN agency, home health agency or independent nurse prior authorization, as applicable. MassHealth or its designee may also authorize other medically necessary LTSS including, but not limited to, Personal Care Attendant (PCA) Services, Therapy Services, Durable Medical Equipment (DME), Oxygen and Respiratory Therapy Equipment, and Prosthetic and Orthotics.

(5) Discharge Planning. The clinical manager may participate in member hospital discharge-planning meetings as necessary to ensure that medically necessary LTSS necessary to discharge the member from the hospital to the community are authorized and to identify third-party payers.

(6) Service Coordination. The clinical manager will work collaboratively with any other identified case managers assigned to the member.

(7) Clinical Manager Follow-up and Reassessment. The clinical manager will provide ongoing care management for members to

(a) determine whether the member continues to meet the definition of a complex-care member; and

(b) reassess whether services in the service record are appropriate to meet the member's needs.

(B) CSN Agency Care Management Activities. The CSN agency must closely communicate and coordinate with the MassHealth agency's or its designee's clinical manager about the status of the member's nursing needs, in addition, but not limited to,

(1) The amount of authorized CSN hours the agency is able and unable to fill upon agency admission, and periodically with any significant changes in availability;

(2) Any recent or current hospitalizations or emergency department visits, including providing copies of discharge documents, when known;

(3) Any known changes to the member's nursing needs that may affect the member's CSN needs;

(4) Needed changes in the agency's CSN PA; and

(5) Any incidents warranting an agency to submit to MassHealth or its designee an incident report. See 130 CMR 438.415(D)(2).

(130 CMR 438.414 (emphasis added).)

The regulation governing clinical eligibility for skilled nursing services states:

(A) Clinical Criteria for Nursing Services.

(1) A nursing service is a service **that must be provided by an RN or LPN to be safe and effective**, considering the inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.

(2) Some services are nursing services on the basis of complexity alone (for example, intravenous and intramuscular injections). However, **in some cases**, **a service that is ordinarily considered unskilled may be considered a nursing service because of the patient's condition**. This situation occurs when only an RN or LPN can safely and effectively provide the service.

(3) When a service can be safely and effectively performed (or self-administered) **by the average nonmedical person** without the direct intervention of an RN or LPN, the service is not considered a nursing service, unless there is no one trained and able to provide it.

(4) The CSN agency must assess the member to ensure that continued nursing services are necessary.

(5) Medical necessity of services is based on the condition of the patient at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period.

(6) A member's need for nursing care is based solely on their unique condition and individual needs, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

(B) Clinical Eligibility for CSN Services. A member is clinically eligible for MassHealth coverage of CSN services when all of the following criteria are met.

(1) There is a **clearly identifiable, specific medical need for a nursing visit** to provide nursing services, as described in 130 CMR 438.410(A), of more than two continuous hours;

(2) The CSN services are medically necessary to treat an illness or injury in accordance with 130 CMR 438.410; and

(3) Prior authorization is obtained by the CSN agency in accordance with 130 CMR 438.411.

(130 CMR 438.410 (emphasis added).)

The MassHealth agency pays for only those CSN services that are medically necessary. (130 CMR 438.419(B).)

(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: *Potential Sources of Health Care*, or 517.007: *Utilization of Potential Benefits*.

(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.)

(C) A provider's opinion or clinical determination that a service is not medically necessary does not constitute an action by the MassHealth agency.

(D) Additional requirements about the medical necessity of MassHealth services are contained in other MassHealth regulations and medical necessity and coverage guidelines.

(E) Any regulatory or contractual exclusion from payment of experimental or unproven services refers to any service for which there is insufficient authoritative evidence that such service is reasonably calculated to have the effect described in 130 CMR 450.204(A)(1).

(130 CMR 450.204.)

At issue in this case is MassHealth authorization for CSN services for the appellant. The dispute between the parties largely arises from the nature of how CCM authorizes CSN services. MassHealth, through CCM, only allows time for clearly identifiable nursing services. (See 130 CMR 438.402; 438.410(B).) It is the primary caregiver's responsibility to "determine when authorized CSN hours … [are] used in order to best support the member's needs." (130 CMR 438.411, (G).) Therefore, if the clearly identifiable nursing services do not total 24 hours of nursing care, there will be a gap in nursing scheduling. The realities of scheduling would make it impossible to schedule a nurse to appear for 3 minutes to perform an assessment and then disappear again if there are no other compensable nursing services to be provided at that time.

MassHealth completed an LTSS Needs Assessment on January 30, 2025, and determined that the appellant required a total of 114 nursing hours per week, plus an additional 6 hours for administrative and documentation time. PCA services were approved at 27 hours per week and 39.5 hours of CCA services per week were approved. The appellant accepted many of the times authorized by CCM. After conversation, the appellant also accepted the time MassHealth calculated for "Cardiac/Autonomic Instability" and for "Other considerations in Skilled Care Needs," as they related to how MassHealth calculated additional time for responding to autonomic storms. The appellant continued to raise specific disputes with regard to the following.

Respiratory

Suction Type/frequency

MassHealth authorized 120 minutes per day for suctioning based upon an average of 30 suctioning passes a day. Generally, MassHealth allowed 3 minutes for an uncomplicated suctioning, but 5 minutes were allowed if saline were used to thin secretions. In the morning, MassHealth had authorized 25 minutes based upon 5 interventions lasting 5 minutes each. Included with any suctioning was "respiratory assessment," and additional suctioning was anticipated to occur during other specific treatments, such as chest physiotherapy.

The appellant requested 50 minutes for morning suctioning instead of 25 minutes. The appellant's mother felt that MassHealth's estimate for how long a suctioning pass takes was low. Mostly, the appellant argued that additional time was needed to acclimate the appellant to the sound of the

suctioning device. This is a medically necessary task, as the appellant is at high risk for seizures at this time of the day. However, it is unclear how this task could be considered a "nursing service."

MassHealth correctly argues that the act of turning on the machine early is not a nursing task, and this can be performed by a non-skilled PCA or CCA in conjunction with a nurse. The appellant argues that this ignores the realities of scheduling. The appellant has more than 24-hour care if all PCA and CCA hours are used. This anticipates the appellant can have both a nurse and a CCA or PCA working together at various points during the week.

As will be discussed, the appellant's mother testified that the entire process of transferring the appellant from the ventilator to capping the trach takes approximately 30 to 45 minutes. MassHealth allowed 10 minutes for the nursing services required to transfer from the vent to room air, plus 5 minutes for managing equipment, plus 25 minutes for suctioning, which total 40 minutes. This is the average for the range provided by the appellant's mother regarding how long the process should take, and it does not take include the time authorized for responding to O2 desaturation.

This aspect of the appeal is DENIED.

O2 Desaturations frequency

MassHealth allowed 129 minutes per day to respond to O2 desaturation. This includes 15 minutes per desaturation, 5 times per day. The appellant requested that the 15 minutes per episode be increased to 25 minutes per episode. The appellant pointed to nursing notes regarding how long the appellant stayed on supplemental oxygen during his morning transition from ventilator to room air. The submitted nursing notes do not reflect that O2 desaturation occurs every day, let alone 5 times every day. The appellant's mother testified that the main O2 desaturation concern arises when transitioning the appellant from his ventilator to room air. Otherwise, she testified that 5 desaturation events would be the maximum number of events in a day. The appellant's mother testified that other desaturation events may not require any intervention, or sometimes they require 10-20 minutes of assistance if the appellant needs to be brought into another room and connected to supplemental oxygen through his trach collar.

MassHealth seeks to find averages that accommodate the broad range of experiences that its complex members may have across a year. It is possible the time per intervention is low, but it appears that the frequency of O2 desaturation interventions is high. Given this evidence, I cannot find that the total time allowed by MassHealth is in error for O2 desaturation events. Therefore, this aspect of the appeal is DENIED.

Gastro-Intestinal (GI)/Nutrition

Oral feeds

MassHealth allowed 40 minutes per day for a nurse to assist with oral feeding every day. It is unclear why. MassHealth argued that the task of mixing the food and feeding the appellant was approved under PCA time, and that is why it should not be allowed as a nursing service. The appellant's mother argued that the time should be increased to allow for the nurse to feed the appellant instead of the PCA. The appellant's mother feels that PCAs are not reliable in preparing the food, as they cannot do it without supervision from a nurse. To the extent that a nurse needs to supervise a PCA preparing foods for the appellant, that time is covered in the 10 minutes of nursing time per meal allowed. The fact that the appellant's mother cannot hand the entire task over to a PCA does not mean that the entire task requires the skill of a nurse. This appeal is DENIED with regards to oral feeds.

Genito-Urinary (GU)

Catheter care/frequency

The appellant requests 5 minutes per day to allow a nurse to apply the condom catheter. MassHealth allowed time for checking skin integrity and to assess urine discharge. No time was allowed for applying the catheter because it was not deemed a skilled task. However, no time is allowed for the PCA to perform this specific task. The PCA authorization only references absorbent briefs. Furthermore, both Plans of Care identify applying the catheter as a nursing task. Therefore, the appellant's requested 5 minutes per day shall be APPROVED.

Wound Care/Skin

Wound Care frequency

Wound care was allowed at 5 minutes per day to care for a pinprick wound in the appellant's peri-area. The appellant's mother testified that this care is provided every time they clean the appellant's peri-area. The PCA evaluation identified the appellant as receiving peri care 6 times per day. The appellant only requested 20 more minutes per day to provide wound care. This is reasonable in light of the location of the wound. MassHealth offered no specific objections to this requested assistance during the appeal.

This appeal is APPROVED in part with regard to wound care frequency.

Skilled assessment/Skin

MassHealth allowed 5 minutes, 3 times per day to assess the appellant's skin and identify how to treat a cyst if one is developing. The appellant's mother argued additional time was needed

because the best way to prevent cysts from becoming painful was to apply a damp cloth and over-the-counter ointment several times a day. While determining when this intervention is needed would be a skilled task, the intervention of applying the damp cloth and ointment is not. As assessing and identifying the course of treatment is already covered 3 times per day, this appeal is DENIED with regards to additional skin assessments.

Musculoskeletal

Passive range of motion (PROM)

The appellant asks that time for PROM be moved from PCA time to nursing time. MassHealth acknowledged that PROM can be a skilled task based upon the complexity of the member's medical conditions. MassHealth's representatives also emphasized the PCA evaluation notes which recorded the appellant's mother stating that the nurses do not provide PROM. It is possible these notes from the PCA evaluation are in error, as the nursing notes from around that time document that nurses are providing the PROM. Both Plans of Care indicate that PROM should be considered a skilled task for the appellant, albeit the Home Health Plan of Care also identifies it as a CCA task.

This appeal shall be APPROVED in part with regards to PROM. MassHealth shall move 60 minutes per day from PCA time to skilled nursing time.

Stander

This appeal is DENIED with regards to the requested time for a stander. I can find no evidence in the clinical documentation that orders that the appellant be placed in a stander. There is documentation that a stander exists, but it does not appear to be used by the appellant. The appellant's mother testified that she is using the Sara lift to give the appellant time for partial weight-bearing. MassHealth's representatives testified that using a stander is akin to using a lift to transfer the appellant. The PCA is undoubtedly authorized to use the Sara lift to transfer the appellant, therefore, there is insufficient evidence to find that using a stander would be a skilled task.

Skilled Assessment/Respiratory & Neurological

The appellant's Pitt Hopkins syndrome requires regular respiratory assessments in order to identify if the appellant has stopped breathing. The appellant's Lennox-Gastaut Syndrome requires regular neurological checks to ensure he is not having a seizure. Because a seizure lasting more than 5 minutes requires medical intervention, the appellant argues that assessments should be authorized every 5 minutes. The appellant's goal is to ensure 24-hour nursing services to ensure someone is available to provide interventions when the need for them arises.

MassHealth's response is that these assessments occur whenever a nurse is in the room providing nursing services, so there is no reason to authorize them on their own. To the extent that they are

requested in the absence of other nursing services, they are "anticipatory." By "anticipatory," MassHealth seems to be arguing that: time is authorized for all specifically identified interventions need by the appellant; assessment is implicit in nursing interventions; therefore, all needed assessment time is already authorized since time for the needed nursing intervention is authorized.

Ultimately, I cannot approve additional assessment time based upon the administrative record before me. There do not appear to be standing orders for a nursing assessment to be performed every 5 minutes. MassHealth has authorized pulse oximetry checks on an hourly basis, which implicitly includes a visual assessment of the appellant, but there does not appear to be a clinical order for more regular respiratory assessments. Similarly, [redacted] testified that a nursing intervention is necessary **within 5 minutes** of an assessed seizure, but she agreed that a non-nurse could assess whether the appellant was having a seizure.

It must be noted that the definition of "nursing services" includes "assessment" as a task. If the record showed that a nurse needed to perform a clinical assessment every 5 minutes, some additional time could be allowed. However, some gap would remain within the 24-hour schedule.

Because the requested respiratory and neurological assessments are not themselves a "clearly identifiable, specific medical need for a nursing visit" documented in the administrative record, they cannot be the basis for additional nursing hours at this time. This aspect of the appeal is DENIED.

Order for MassHealth

As of the date of this decision, increase the appellant CSN hours by 85 minutes per day, and decrease the appellant's PCA hours by 60 minutes per day.

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.

Implementation of this Decision

If this decision is not implemented within 30 days after the date of this decision, you should contact your CCM Case Manager. If you experience problems with the implementation of this decision, you should report this in writing to the Director of the Board of Hearings, at the address on the first page of this decision.

Christopher Jones
Hearing Officer
Board of Hearings

cc: [redacted]

MassHealth Representative: Linda Phillips, UMass Medical School - Commonwealth Medicine, Disability and Community-Based Services, 333 South Street, Shrewsbury, MA 01545-7807