Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2506063
Decision Date:	06/17/2025	**Hearing Date:**	05/22/2025
Hearing Officer:	Amy B. Kullar, Esq.	**Record Open to:**	05/27/2025

Appearances for Appellant:

[redacted]

Appearances for MassHealth MCO (Health New England):
Orlando Leon, Supervisor, Complaints & Appeals
Leah Duquette, R.N., Utilization Review Nurse;
Dawn Martin, R.N., Manager, Utilization Management
Joseph Tchaikovsky, Complaints & Appeals Coordinator

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171

APPEAL DECISION

Appeal Decision:	Denied	**Issue:**	Managed Care Organization - Denial of Internal Appeal; Skilled Nursing Facility Services
Decision Date:	06/17/2025	**Hearing Date:**	05/22/2025
MCO Health New England's Reps.:	Orlando Leon, *et al.*	**Appellant's Reps.:**	[redacted]
Hearing Location:	Quincy Harbor South 4 (Telephone)	**Aid Pending:**	Yes

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice of denial of an expedited internal appeal dated April 11, 2025, Health New England (HNE), a Managed Care Organization (MCO) contracted with MassHealth, denied the appellant's expedited internal appeal of a denial for Level 1 Skilled Nursing – SNF01, because the appellant "does not meet skilled nursing criteria as you do not require at least minimum assist with physical therapy or occupational therapy. Per MassHealth Criteria (Provider Manual Series 130 CMR 456.409), if you do not require daily skilled nursing care or nursing care three times a week and your medical condition and/or functional limitation(s) do not require the level of care and training of a daily licensed physical therapist then the denial will maintain. To make this determination, we used MassHealth Criteria (Provider Manual Series 130 CMR 456.409)." Exhibit 1. The appellant filed this appeal in a timely manner on April 16, 2025. *See* 130 CMR 610.015(B) and Exhibit 2. The MCO's decision to deny authorization of a requested service is grounds for appeal. *See* 130 CMR 610.032(B).

The record was briefly held open until May 27, 2025, while this Hearing Officer obtained additional information from the parties via email.

Action Taken by MCO

HNE, acting on behalf of MassHealth as an MCO, denied the appellant's request for Level 1 – Skilled Nursing – SNF01 because HNE believes that pursuant to 130 CMR 456.409, the appellant does not meet the criteria for skilled nursing care.

Issue

The appeal issue is whether HNE was correct, pursuant to 130 CMR 456.409, in determining that the appellant does not meet the criteria for skilled nursing care.

Summary of Evidence

All parties appeared at hearing via telephone. The Managed Care Organization, Health New England, was represented at hearing by a Complaints & Appeals Supervisor, a Utilization Review Nurse, an R.N. Manager in Utilization Management, and a Complaints & Appeals Coordinator. The appellant appeared at hearing and verified her identity. The appellant was accompanied by an R.N./Patient Advocate from her long-term care facility (hereinafter, "the facility").

On [redacted], the appellant, who is [redacted], was admitted to the facility following a hospital stay due to having "feelings of depression and knee pain." Exhibit 5 at 14. The facility submitted 132 pages from the appellant's medical record prior to the hearing. *See* Exhibit 5. On admission, the appellant had primary diagnoses of major depressive disorder, rheumatoid arthritis, and adult failure to thrive. *Id.* at 106. The appellant's physical therapy plan of care for her time at the facility was certified by the facility's physician for the time period of 3/17/2025-4/15/2025. *Id* at 106-111. Nursing notes dated 3/15/2025-4/6/2025 provide background information about the appellant's living situation in the community and document the care and services that the appellant received at the facility since admission.

The appellant's brother spoke with Social Services at the facility on March 20, 2025, and this interaction was extensively documented in a note in the appellant's medical record. For the last six to seven years, the appellant has resided in the community with her brother and his family; her brother also serves as her health care agent. During the preceding four months leading up to her hospitalization and subsequent admission to the facility, the appellant began exhibiting strange behavior – she stopped eating and spending time with the family, stopped attending activities at the local senior center, and she began hoarding unsanitary items in her room in her brother's house. The appellant was hiding medications and not taking them. The appellant stopped her VNA nurse from visiting. She began having screaming episodes in the middle of the night, was urinating into containers, and having bowel movements in her clothes. By the time she was taken by ambulance to a local hospital in March 2025, the appellant had not showered in at least four weeks. According to the conversation that Social Services had with the

appellant's brother, the family would like her to come home, with supportive services, and the appellant's brother will "willingly assist in any way possible." Exhibit 5 at 46.

Additional nursing notes indicate that the appellant has been independent with all ADLs since March 22, 2025 and continues to be independent with ADLs as of the date of this hearing. *Id.* at 45. On March 24, 2025, a conversation the appellant had with an LPN at the facility was documented in the nursing notes: "Spoke briefly with resident who stated she'd become more depressed due to her failing health and asked brother to call EMS. Which load her to [Local Hospital]. States she needs her meds readjusted. Since being here at [facility] resident participates in therapy. Does not want to interact with other residents." *Id.* at 43. On March 31, 2025, the appellant's Social Worker from the [redacted] called and spoke with a nurse at the facility to receive an update as to the appellant's status, and to find out her date of discharge so that the appellant's services would not be disrupted once she returned to the community. *Id.* at 40. The medical record indicates that the appellant was recently treated for a yeast infection in early [redacted], but the course of treatment was completed successfully. *Id.* at 37. The appellant completed Occupational Therapy (OT) on April 4, 2025, Physical Therapy (PT) on April 6, 2025, and Speech Therapy on April 3, 2025. *Id.* at 27, 17, & 23.

The Utilization Review Nurse was the only person to offer testimony at the hearing on behalf of the MCO. After internal review, HNE denied the appellant's request for additional skilled nursing on March 26, 2025. The appellant then filed a level one expedited internal appeal, and received another denial from HNE for additional skilled nursing on April 11, 2025, which the appellant then appealed to the Board of Hearings. *Id.* at 54. The Utilization Review Nurse opened her testimony by stating that after reviewing the appellant's medical records from the facility, dated March 24, 2025 - April 6, 2025, it is HNE's position that the appellant is largely independent with transfers, mobility, and activities of daily living (ADLs). The Utilization Review Nurse stated that the appellant's medical record indicates that the appellant is independent with getting in and out of bed; she is supervision ("eyes on" only) or contact guard (light, not "hands on") needed for transfers, and the appellant presently ambulates with a 2-wheeled walker, with which she can walk between 50 to 250 feet. Testimony. The appellant is mostly independent, or only needs set-up, for eating, bathing, hygiene, and dressing. The documentation submitted by the appellant's facility indicates that the appellant has a safe discharge plan to her brother's home, which is a single-level home with two steps. Testimony. The Utilization Review Nurse concluded her testimony by stating that under HNE guidelines and Medicaid regulations, specifically, 130 CMR 456.409, the appellant did not meet criteria for continued skilled nursing facility (SNF) services. Testimony.

In response to the testimony from HNE, the appellant's representative testified that the appellant is clinically eligible for skilled nursing because she still requires at least supervision, encouragement, and sometimes hands-on assistance with ADLs such as bathing, toileting, and dressing. The appellant's representative stated that as of the date of the hearing, the appellant

was still receiving physical and occupational therapy at the facility, which are "skilled services[1]." According to her representative, the appellant depends on staff for daily medication management, and this is nursing assistance. The appellant also needs to be motivated by staff daily due to her existing emotional and psychological barriers. Testimony. The appellant's representative asserted that the appellant lacks local family support for her to receive adequate care at home. The appellant's representative stated that the prior living situation with her brother was no longer a viable or healthy arrangement. At this point, the Hearing Officer questioned the appellant as to why she could not return to her brother's home, where she had resided for at least the past six years. The appellant stated only that it was a "bad situation." Testimony. The appellant's representative then noted that the appellant had received treatment for a wound that has since healed and she asserted that "recent flow sheets" document that the appellant periodically needs extensive support with key ADLs on certain days. The appellant and her representative do not consider the current discharge plan to be viable and she needs an alternative living arrangement. Testimony.

After further questioning by the Hearing Officer, the appellant stated that the staff at the facility take care of her and help her get up and ready every day; they feed her. She acknowledged that if she clinically continued to improve, there may be a time in the not-so-distant future when she is no longer eligible for skilled nursing care. After discussion, the appellant agreed that much of the benefit she is receiving from being at the facility is emotional and social in nature. Testimony. The appellant denied being diagnosed with any cognitive impairments but acknowledged that in the past, she has had emotional or psychological issues and infrequent "memory issues." Testimony.

At the conclusion of the hearing, the parties agreed that the record would be held open until May 27, 2025, so that the appellant, through her representative, could submit "current medical records" that she said would show that the appellant currently requires skilled nursing/assistance with ADLs, and also so that HNE could provide a written response to the appellant submission. Exhibit 7. On May 23, 2025, the appellant's representative emailed HNE and the Hearing Officer a 6-page document which contained the recent flow sheets for the appellant dated 4/22/2025-5/22/2025. Exhibit 8. HNE offered no response to the appellant record open submission, and the Hearing Officer closed the administrative record on May 27, 2025.

Findings of Fact

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

[1] HNE submitted a written record that includes the appellant's medical record from the facility and includes Nursing, OT, PT, and Social Services notes. The submitted medical record indicates that the appellant completed OT, PT, and Speech Therapy on April 4, 2025, April 6, 2025, and April 3, 2025, respectively. Nursing notes dated 3/22/2025-4/3/2025 indicate that the appellant is "independent with all ADLs." Exhibit 5.

1. The appellant, who is [redacted] was admitted to the facility on [redacted], after a hospitalization, due to feelings of depression and knee pain. Testimony and Exhibit 5.

2. The appellant was approved for skilled nursing level of care beginning March 15, 2025. Exhibit 5.

3. On March 26, 2025, HNE determined that the appellant no longer required assistance with three ADLs and did not meet the criteria for skilled nursing care. Exhibit 5.

4. The appellant filed an expedited internal appeal on April 10, 2025, which prompted the MCO denial notice dated April 11, 2025, currently under appeal before the Board of Hearings. Exhibit 1.

5. On April 16, 2025, the appellant timely appealed the April 11, 2025 denial notice to the Board of Hearings. Exhibit 2.

6. Appellant is independent with all activities of daily living (ADLs) including bathing, oral and personal hygiene, eating, lower and upper body dressing, toileting, bed mobility, ambulation with a walker; the appellant only needs supervision during transfers and some verbal cueing with medication management of oral medications.

Analysis and Conclusions of Law

MassHealth members younger than 65-years-old must enroll in a Managed Care Organization available for their coverage type, unless they are excluded from such participation. 130 CMR 508.001(A); 130 CMR 508.002(A). The MCO is responsible for delivering "the member's primary care, determine if the member needs medical or other specialty care from other providers, and determine referral requirements for such necessary medical services." 130 CMR 508.004(B)(1); *see also* 130 CMR 450.105; 130 CMR 508.001(A). "All medical services to members enrolled in an MCO … are subject to the authorization and referral requirements of the MCO." 130 CMR 508.004(B)(2); *see also* 130 CMR 450.105(A)(3).

Whenever an MCO makes a coverage decision, it must provide notice to the affected member. 130 CMR 508.011. An MCO has 30 days to resolve any internal appeals, and the member then has 120 days to request a fair hearing from the Board of Hearings. *See* 130 CMR 508.012; 130 CMR 610.015(B)(7).

The MassHealth definition of "medical necessity" is:

> (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 CMR450.317(C), 503.007, or 517.007.

(130 CMR 450.204(A))

This appeal considers whether HNE correctly determined that the appellant did not meet the criteria for skilled nursing in a long-term care facility, and applied the appropriate standards, policies, and regulations in doing so. 130 CMR 456.409 states the following in relevant part regarding clinical eligibility criteria for long-term care services:

To be considered clinically eligible for nursing facility services, a member or MassHealth applicant **must require one skilled service listed in 130 CMR 456.409(A) daily**, *or* **the member must have a medical or mental condition requiring a combination of at least three services from 130 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.

(Emphases added)

It is clear from the written record and the testimony at hearing that the appellant received care from the facility that has led to a great improvement in her health, such that she does not meet the criteria in 130 CMR 456.409 to qualify for skilled nursing in a nursing facility. As attested by both parties at hearing, and as documented by the written record, the appellant does not require

one skilled service listed in 130 CMR 456.409(A) daily, nor does she require a combination of at least three services from 130 CMR 456.409(B) and (C), including one nursing service listed in 130 CMR 456.409(C). The appellant has not participated in OT or PT since April 2025. She needs some supervision and monitoring during transfers, but I was unable to locate anywhere in the written record where it states that the appellant requires hands-on assistance with any ADL. She is independent with the other ADLs listed in 130 CMR 456.409, which includes bathing, dressing, transfers, mobility/ambulation, and eating. She needs some verbal cueing and supervision management of oral medications, but no other ADLs or nursing services.

The appellant and her representative from the facility offered testimony that the appellant prefers to remain in a long-term care facility at present and for the foreseeable future, but they were both unable to credibly tell me why the appellant is unable to return to her previous home with her brother and his family, or why the appellant is unable to reside with one of the other numerous supportive family members that the facility's social workers have spoken to on behalf of the appellant. After questioning the appellant during the hearing, I have serious concerns about whether she understands the reality of her situation. She expressed a desire to remain *indefinitely* at a skilled nursing facility rather than with family or at an assisted living or independent living facility, but she could not articulate why.

Unfortunately, none of the evidence offered by the appellant and her representative shows that the appellant meets the criteria for long-term or skilled nursing care pursuant to the applicable MassHealth regulations. The appellant failed to satisfy her burden of proof to establish eligibility for skilled nursing care.

As the appellant does not meet the criteria in 130 CMR 456.409 for skilled nursing, HNE's determination was correct, and this appeal is DENIED.

Order for MCO

Remove Aid Pending.

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.

Amy B. Kullar, Esq.
Hearing Officer
Board of Hearings

[redacted]

cc: MassHealth MCO Representative: Health New England, James Farrell, Complaints & Appeals, One Monarch Place, #1500, Springfield, MA 01144-1500