

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3725

██████████ 2015
SIGNATURE CONFIRMATION

Request # 673572
Client ID # ██████████

NOTICE OF DECISION

PARTY

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PROCEDURAL BACKGROUND

On ██████████ 2015, Ascend Management Innovations LLC, (“Ascend”), the Department of Social Service’s (the “Department”) contractor that administers approval of nursing home care, sent ██████████ (the “Appellant”) a Notice of Action (“NOA”) denying nursing home level of care (“LOC”) stating that she does not meet the nursing facility level of care criteria.

On ██████████ 2015, the Appellant requested an administrative hearing to contest Ascend’s decision to deny nursing home LOC.

On ██████████ 2015, the Office of Legal Counsel, Regulations, and Administrative Hearings (“OLCRAH”) issued a notice scheduling an administrative hearing for ██████████ 2015.

On ██████████ 2015, in accordance with sections 17b-60, 17-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing. The following individuals were present at the hearing:

██████████, Appellant
Dana Kupec, LCSW, Director of Social Work at Freshriver Healthcare
Linda Orłowski, MSW, Director of Social Work at Freshriver Healthcare

Charlaine Ogren, LCSW, Alternate Care Unit, DSS
Charles Bryan, RN, Alternate Care Unit, DSS
Connie Tanner, MS, Senior Operations Manager, ASCEND (participated by telephone)
Carla Hardy, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Ascend's decision that the Appellant does not meet the criteria for nursing facility LOC was correct.

FINDINGS OF FACT

1. On [REDACTED] 2014, the Appellant was admitted to Freshriver Healthcare from Danbury Hospital for a 60-day short-term stay. Freshriver Healthcare is a chronic and convalescent nursing home (Hearing Summary, Exhibit 8: Connecticut LTC Level of Care Determination Form).
2. The Appellant's medical diagnosis was: alcohol abuse, fall secondary to ETOH abuse, osteoarthritis, (L) foot fx, cerebral hemorrhage and alcohol withdrawal (Exhibit 8).
3. The Appellant is 55 years old (DOB [REDACTED]/59) and resides in a nursing facility (Appellant's Testimony, Exhibit 8).
4. The Appellant applied for the Money Follows the Person program ("MSP".) As of the date of this hearing the application was still pending (Hearing Record, Exhibit 8).
5. On [REDACTED] 2014, Freshriver Healthcare submitted the LOC evaluation form to Ascend. Ascend approved the Appellant for 120 days of extended short term care due to the fractured left foot and continued need for assistance with bathing, transferring, toileting and dressing (Hearing Summary).
6. On [REDACTED] 2014, Freshriver Healthcare submitted a third LOC screen to Ascend and requested a retrospective review to begin on [REDACTED] 2014. Ascend approved the Appellant for 60 days of extended short term care due to her status post fall with the left foot fracture in addition to not having a safe and appropriate discharge plan (Hearing Summary).
7. On [REDACTED] 2015, Freshriver Healthcare submitted a NF LOC Screen to Ascend which described the Appellant's current ADL and Instrumental Activities of Daily Living support needs as follows: The Appellant is

independent with bathing, toileting, mobility, transferring and continence. She did not need assistance with meal preparation (Hearing Summary).

8. On [REDACTED] 2015, Ascend conducted an onsite Medical Level of Care Evaluation (Exhibit 6: Medical Level Evaluation).
9. Ascend assessed the Appellant as able to complete her activities of daily living without assistance and not requiring the continuous nursing services delivered at the level of the nursing facility. The Appellant was able to complete all ADL's without assistance (Exhibit 5: Level of Care Report, Exhibit 6: CT Medical Level of Care Evaluation).
10. The ADL Measures include bathing, dressing, eating, toileting, continence, transferring and mobility (Exhibit 3: Connecticut ADL Measures and Measurements).
11. The Appellant is able to complete all seven ADL's (Appellant's Testimony).
12. The Appellant's medical diagnoses/history includes: Osteoarthritis, Cerebral hemorrhage, Insomnia, scoliosis, hypothyroidism, a fall, fractured left foot, alcohol abuse and alcohol withdrawal (Exhibit 6).
13. The Appellant's current medications include: Levothyroxine, Escitalopram, Folic acid, Tab-A Vite Multivite, Vitamin B-1, Docusate Sodium, Hydroxyzine Pam, Senexon-S, Milk of Magnesia, Bisac-Evac, Enema Latex-free, Lorazepam, Acetaminophen, Acephen and Oxycodone HCL (Appellant's Exhibit A: Physician's Order Sheet).
14. Freshriver Healthcare nursing staff dispenses all of the Appellant's medications (Exhibit 4: Ascend Notice of Action dated [REDACTED]/15, Appellant's Testimony).
15. The Appellant does not require any rehabilitative therapy services (Exhibit 6).
16. The Appellant is fully oriented to self, place, and time (Exhibit 6).
17. The Appellant does not have an uncontrolled chronic medical condition requiring continuous skilled nursing services and substantial assistance with personal care on a daily basis (Exhibit 6).
18. Ascend determined that the Appellant does not meet Connecticut Minimum Admission Criteria for nursing facility LOC. (Hearing Record, Exhibit 4: Notice of Action, Denial of Nursing Facility LOC, [REDACTED]/15)
19. Ascend determined that nursing facility services are not medically necessary for the Appellant as her needs could be met through a combination of medical

and social services delivered outside of the nursing facility setting (Hearing Summary, Exhibit 4).

20. On [REDACTED] 2015, Ascend issued a Notice of Action to the Appellant stating that she does not meet the medical criteria for nursing facility LOC and as a result, she would not be eligible for nursing facility services funded by Medicaid. (Hearing Record, Exhibit 4)

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.
2. State regulations provide that “the department shall pay for an admission that is medically necessary and medically appropriate as evidenced by the following:
 - (1) certification by a licensed practitioner that a client admitted to a nursing facility meets the criteria outlined in section 19-13-D8t(d)(1) of the Regulations of Connecticut State Agencies. This certification of the need for care shall be made prior to the department’s authorization of payment. The licensed practitioner shall use and sign all forms specified by the department;
 - (2) the department’s evaluation and written authorization of the client’s need for nursing facility services as ordered by the licensed practitioner;
 - (3) a health screen for clients eligible for the Connecticut Home Care Program for Elders as described in section 17b-342-4(a) of the Regulations of Connecticut State Agencies;
 - (4) a preadmission MI/MR screen signed by the department; or an exemption form, in accordance with 42 CFR 483.106(b), as amended from time to time, for any hospital discharge, readmission or transfer for which a preadmission MI/MR screen was not completed; and
 - (5) a preadmission screening level II evaluation for any individual suspected of having mental illness or mental retardation as identified by the preadmission MI/MR screen.” Conn. Agencies Regs. Section 17b-262-707 (a).
3. State regulations provide that “Patients shall be admitted to the facility only after a physician certifies the following:
 - (i) That a patient admitted to a chronic and convalescent nursing home has uncontrolled and/or unstable conditions requiring continuous skilled nursing services

and /or nursing supervision or has a chronic condition requiring substantial assistance with personal care, on a daily basis.”

Conn. Agencies Regs. § 19-13-D8t(d)(1)(A).

5. Section 17b-259b of the Connecticut General Statutes states that "Medically necessary" and "medical necessity" defined. Notice of denial of services. Regulations. (a) For purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition. (b) Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity. (c) Upon denial of a request for authorization of services based on medical necessity, the individual shall be notified that, upon request, the Department of Social Services shall provide a copy of the specific guideline or criteria, or portion thereof, other than the medical necessity definition provided in subsection (a) of this section, that was considered by the department or an entity acting on behalf of the department in making the determination of medical necessity.
6. Ascend correctly used clinical criteria and guidelines solely as screening tools.
7. Ascend correctly determined that the Appellant is independent with all of her ADLs.

8. Ascend correctly determined that the Appellant does not have a chronic medical condition requiring substantial assistance with personal care on a daily basis.
9. Ascend correctly determined that the Appellant does not have uncontrolled and/or unstable medical conditions requiring continuous skilled nursing services and /or nursing supervision.
10. Ascend correctly determined it is not clinically appropriate that the Appellant reside in a nursing facility.
11. Ascend correctly determined that nursing facility services are not medically necessary for the Appellant, because her medical needs could be met with services offered in the community.
12. Ascend correctly determined that it is not medically necessary for the Appellant to reside in a skilled nursing facility and on [REDACTED] 2015, correctly denied her request for continued approval of long-term care Medicaid.

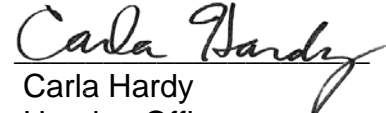
DISCUSSION

The Appellant does not meet the medical criteria for nursing facility LOC and is not eligible for continued nursing facility services funded by Medicaid because the Appellant does not have a chronic/unstable medical condition requiring skilled nursing care and is not in need of substantial assistance with her personal care needs on a daily basis.

The Appellant entered Fresh River Healthcare on [REDACTED] [REDACTED] 2014, after hospitalization for a fall and fractures to multiple metatarsals. After the care received in the nursing facility her health status has improved and stabilized. The Appellant testified that she does not need assistance with any ADL's. The Appellant no longer requires the LOC provided by the nursing facility. The type of services that the Appellant requires can be administered in the community setting through medical and social services.

DECISION

The Appellant's appeal is **DENIED**.


Carla Hardy
Hearing Officer

Pc: Kathy Bruni, Manager, Alternate Care Unit, DSS, Central Office
Charlaine Ogren, Alternate Care Unit, DSS, Central Office
Charles Bryan, Alternate Care Unit, DSS, Central Office
Connie Tanner, Senior Operations Manager, Ascend Management Innovations

RIGHT TO REQUEST RECONSIDERATION

The appellant has the right to file a written reconsideration request within **15** days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Administrative Hearings and Appeals, 55 Farmington Avenue, Hartford, CT 06105-3725.

RIGHT TO APPEAL

The appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 55 Elm Street, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue, Hartford, CT 06105-3725. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or the Commissioner's designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the appellant resides.