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

[redacted] 2019
SIGNATURE CONFIRMATION

Client ID#: [redacted]
HEARING ID#: [redacted]

NOTICE OF DECISION

PARTY

[redacted]

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2018, [redacted] (the "Facility") sent [redacted] (the "Appellant") a notice stating that he does not meet the level of care criteria to reside in a nursing facility beyond 60 days from his admission. Ascend Management Innovations LLC, ("Ascend") the Department of Social Services' (the "Department") vendor that administers approval of nursing home care, had approved the Appellant for 60 days of long-term care services in a nursing facility from the date of admission to the Facility.

On [redacted], 2018, the Appellant requested an administrative hearing to contest Ascend's decision.

On [redacted] 2019, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2019.

On [redacted] 2019, 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 at [redacted]. The following individuals were present at the hearing:

[redacted], the Resident
Jaimie Feril, RN, Ascend
[redacted], Administrator of Facility
[redacted], Director of Nursing, [redacted]
[redacted], Admissions Coordinator, [redacted]

[redacted], Social Worker, [redacted]
Benille St. Jean, RN, DSS
Roberta Gould, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Ascend's decision that the Appellant does not meet the skilled nursing level of care criteria was correct.

FINDINGS OF FACT

1. The Appellant's date of birth is [redacted]. (Exhibit 3: Level of Care Determination form)

2. On [redacted] 2018, the Resident was admitted to the Facility with a diagnosis of HIV, generalized weakness, Polysubstance Dependence, non-traumatic rhabdomyolysis, pleuritic chest pain, cocaine use, chronic Hepatitis B, pneumonia associated with acquired immune deficiency syndrome, and a right upper lung mass. (Exhibit 3 and Hearing summary)

3. On [redacted] 2018, the Facility submitted a Nursing Facility Level of Care screening form to Ascend. (Hearing summary)

4. Upon admission, the Resident required assistance with mobility and medication supports. (Exhibit 3 and Hearing summary)

5. The Resident is currently independent with all Activities of Daily Living ("ADLs") and Instrumental Activities of Daily Living ("IADLs"). (Director of Nursing testimony and Resident's testimony)

6. On [redacted] 2018, Ascend determined that the Resident met the nursing facility level of care for a time-limited period of 60 days. Ascend determined that short-term approval would expire on [redacted] 2019. (Exhibit 2: Ascend notice of action dated [redacted]/2018 and Hearing summary)

7. On [redacted] 2019, the Resident left the Facility on his own volition. (Resident's testimony and Administrator's testimony)

8. On [redacted] 2019, the Resident returned to the Facility because he did not have any place to live. (Resident's testimony)

9. The Resident is seeking a safe environment to live outside of the skilled nursing facility and would like to enter a substance abuse treatment program. (Resident's testimony)

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. Connecticut Agencies Regulations Section 17b-262-707(a) provides 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. .
    (2) 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;
    (3) the department's evaluation and written authorization of the client's need for nursing facility services as ordered by the licensed practitioner;
    (4) 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;
    (5) 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
    (6) 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."

3. Connecticut Agencies Regulations Section 17b-262-707(b) provides that the Department shall pay a provider only when the department has authorized payment for the client's admission to that nursing facility.

4. Connecticut Agencies Regulations Section 19-13-D8t(d)(1)(A) provides 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.

5. Section 17b-259b of the Connecticut General Statures 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.

The Appellant is independent with all ADLs and IADLs.

It is not clinically appropriate that the Appellant reside in a nursing facility.

Ascend Management Innovations is correct in its determination that the Appellant does not meet the medical criteria for nursing facility level of care.

DISCUSSION

After reviewing the evidence and testimony presented at this hearing, I find that the Appellant is independent with all of his ADLs and IADLs. On [redacted] 2019, the Appellant left the Facility on his own and only returned because he did not have a permanent place to live. The Appellant testified that he is seeking placement outside of the long-term care facility. Ascend was correct in their decision that the Appellant does not meet medical necessity criteria for nursing home level of care.

DECISION

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

Roberta Gould
Hearing Officer

PC: Shirlee Stoute, DSS Central Office
Laurie Filippini, DSS Central Office
Pamela Adams, DSS Central Office
Angela Gagen, DSS Central Office
Connie Tanner, Ascend
Joi Shaw, Ascend
Jaime Johnson, Ascend

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. 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.