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

[redacted] 2020
SIGNATURE CONFIRMATION

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

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2020, Ascend Management Innovations ("Ascend"), the Department of Social Services' (the "Department") vendor that administers approval of nursing home care, sent [redacted] (the "Resident") a notice stating that he does not meet the level of care criteria to reside in a nursing facility.

On [redacted] 2020, the Appellant requested an administrative hearing to contest Ascend's decision.

On [redacted], 2020, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2020.

On [redacted] 2020, 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] Nursing Facility. The following individuals were present at the hearing:

[redacted], the Resident
Paul Cook, MSW, RN, Ascend
Jean Denton, Lead Clinician Reviewer, Ascend
[redacted], Nursing Supervisor, [redacted]
Allison Weingart, RN, Community Options DSS
[redacted], Director Social Services, [redacted]
Roberta Gould, Hearing Officer

At the request of the Department the hearing record was re-opened for the submission of additional evidence. The hearing record closed on [redacted], 2020.

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], the Resident was admitted to [redacted] Hospital with a diagnosis of pneumonia, acute chronic heart failure, tachycardia, AIDS, hepatitis C, anxiety, and Substance Abuse Disorder. (Exhibit 15: Medical history and physical and Hearing summary)

3. On [redacted], [redacted] Hospital submitted a Nursing Facility Level of Care ("NFLOC") screening form to Ascend indicating that the Resident required hands on assistance with the following Activities of Daily Living ("ADLs"): bathing, dressing, toileting, mobility and transferring. The hospital also indicated that the Resident did not require assistance or supervision with his Instrumental Activities of Daily Living ("IADLs"). (Hearing summary)

4. The Resident has been prescribed ASA, Lipitor, Coreg, Dapsone, Prozac, Lasix, Neurontin, Genvoya, Vistaril, and Zaroxolyn. (Exhibit 4: Medical level of care evaluation dated [redacted])

5. Ascend approved the Resident for a short-term stay of 90 days. This approval expired on [redacted]. (Hearing summary)

6. On [redacted], the Resident was admitted to [redacted] (the "Facility"). (Hearing summary)

7. On [redacted], the Facility submitted a NFLOC screening form to Ascend indicating that the Resident required supervision with bathing, dressing, and eating/feeding, and was capable of preparing meals with minimal assistance. Ascend approved the Resident for another short-term stay. This approval expired on [redacted]. (Hearing summary)

8. In [redacted], the Resident completed an application for the Money Follows the Person ("MFP") program in order to receive assistance with transitioning from the Facility to a community setting. (Resident's testimony)

9. On [redacted], the Facility conducted a psychiatric evaluation and determined that the Resident's occasional anxiety and low mood episodes were less frequent. The Resident completed Social Security Disability application forms at this time with assistance from the Facility. (Exhibit 13: Psychiatric evaluation consultation dated [redacted])

10. On [redacted], the Facility submitted a NFLOC screening form to Ascend indicating that the Resident required hands on assistance with mobility and transfers, but that he required no other assistance or supervision. (Hearing summary)

11. On [redacted], Ascend conducted a Level I Medical On-Site Review that included the Resident's history and physical, physician's order, practitioner certification, psychological progress notes, psychiatric evaluation, minimum data set, and resident flow sheet. Ascend's physician, [redacted], M.D. determined that the Resident does not require continuous nursing services delivered at a Nursing Facility level because his needs could be met in a less restrictive setting through a combination of medical, psychiatric, and social services delivered outside of the nursing facility setting. (Exhibit 3: Level of care report, Exhibit 4 and Hearing summary)

12. On [redacted], Ascend determined that the Resident was independent with all ADLs, did not require rehabilitative services, but did require supervision with medication management. It was also noted that the Resident is working with a MFP social worker to obtain housing. (Exhibit 4 and Hearing summary)

13. On [redacted], Ascend issued a notice to the Resident indicating that he does not meet the nursing facility level of care as it is not medically necessary for him because it is not considered effective for him and is not clinically appropriate. (Exhibit 2: Notice of denial of nursing facility level of care dated [redacted] and Hearing summary)

14. On [redacted], at the administrative hearing, the Facility's Nursing Supervisor and Director of Social Services indicated that there had been a change in the Resident's medical status. (Hearing record)

15. On [redacted], the Facility submitted a NFLOC form to Ascend in order to re-evaluate the Resident's medical status. Medical documentation submitted indicates that he receives nursing care to monitor vital signs, pain and daily weights, and to assist with medication management. The Resident does not receive physical therapy, occupational therapy or assistance with ADL's and has no cognitive impairments. Ascend determined that there is no change in the Resident's medical care needs since his last NFLOC review. (Exhibit 16: LTC level of care determination form dated [redacted])

16. On [redacted], Ascend issued a new notice to the Resident indicating that he is being denied nursing facility level of care because it is not clinically appropriate nor medically necessary for him. (Exhibit 17: Notice of denial of nursing facility level of care dated [redacted])

17. The issuance of this decision is timely under Connecticut General Statutes §17b-61(a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The Resident requested an administrative hearing on [redacted] 2020. However, the State of Connecticut, by executive order, further extended the issuance of such decisions by 30 additional days, and the Hearing Officer re-opened the hearing record through [redacted] 2020, to allow for the submission of an additional medical evaluation. Because of the delay in the close of the hearing record, this final decision is not due until [redacted] 2020, and is therefore timely.

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."

On [redacted], the Resident was correctly admitted to the Facility after a medical evaluation indicated that he had uncontrollable and unstable conditions that required continuous skilled nursing services.

5. Section 17b-259b of the Connecticut General Statures provides 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 Resident is currently not receiving any skilled nursing, PT or OT services at the Facility and is independent with all ADLs and IADLs. He does require supervision with medication management, which can be provided in a community setting.

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.

On [redacted] 2020, Ascend was correct when it issued the Resident a notice of Denial of Nursing Facility Level of Care.

On [redacted] 2020, Ascend was correct when it issued the Resident a notice of Denial of Nursing Facility Level of Care.

DISCUSSION

After reviewing the evidence and testimony presented at this hearing, I find that the Resident does not require continuous skilled nursing services and nursing supervision on a daily basis. Evidence in the hearing record reflects that he is independent with all of his ADLs and IADLs and that, based on a thorough assessment of the individual and his medical condition, his needs could be met with a combination of medical, psychiatric and social services in a community setting. The Resident has indicated that he has completed an application for MFP to secure housing in the community and has also completed an application for Social Security Disability benefits. Evidence clearly shows that, with assistance through home health, visiting nurse, and possibly psychiatric services, his needs could be met outside of the skilled nursing facility. Ascend was correct in their decision that the Appellant does not meet the medical necessity criteria for nursing home level of care because it is not clinically appropriate in terms of the level of services provided and it is not medically necessary for his condition.

DECISION

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

Roberta Gould
Hearing Officer

PC: Angela Gagen, DSS Central Office
Connie Tanner, Ascend
Paul Cook, Ascend
Jaime Johnson, Ascend
[redacted]

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.