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

Case ID # [redacted]
Client ID [redacted]
Request # 152996

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2020, Ascend Management Innovations LLC/Maximus, ("Ascend"), the Department of Social Service's (the "Department") contractor that administers approval of nursing home care, sent [redacted] (the "Appellant") a Notice of Action ("NOA") denying the nursing home level of care ("LOC").

On [redacted], 2020, the Appellant requested an administrative hearing to contest Ascend's decision to discontinue nursing home LOC effective [redacted] 2020.

On [redacted] 2020, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling an 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. The following individuals were present at the hearing:

[redacted], Appellant
[redacted]
Pat Zackowski, Registered Nurse, Community Nurse Coordinator, Department of Social Services

Paul Took, Supervisor Registered Nurse, Ascend/Maximus Via Telephone
Swati Sehgal, 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 after [redacted] 2020, was correct.

FINDINGS OF FACT

1. On [redacted], 2019, the Appellant was admitted to [redacted] with diagnoses of cellulitis of the left upper limb, Dysthymic Disorder, diabetes mellitus type II, severe stress, and subarachnoid hemorrhage. (Hearing Summary, Appellant's testimony).

2. The ADL Measures include bathing, dressing, eating, toileting, continence, transferring, and mobility (Exhibit 4: Connecticut ADL Measures and Measurements).

3. On [redacted]7, 2019, [redacted] submitted a Nursing Facility ("NF") Level of Care ("LOC") evaluation form to Ascend. The screen described the Appellant's current Activities of Daily Living ("ADL") needs as requiring supervision with eating/feeding. For Instrumental Activity of Daily Living (IADL), he required total physical assistance with meal preparation. Ascend granted a 90-day short term approval for NF LOC to expire on [redacted] 2019. (Hearing Summary)

4. On[redacted], 2019, [redacted] submitted a Nursing Facility ("NF") Level of Care ("LOC") evaluation form to Ascend. The screen described the Appellant's current ADL needs as requiring supervision with bathing, eating/feeding. For IADLs he does not need supervision or assistance. Based on this information Ascend granted a 60-day short term approval for NF LOC to expire on [redacted], 2019. (Hearing Summary)

5. On [redacted], 2019, [redacted] again submitted a Nursing Facility ("NF") Level of Care ("LOC") evaluation form to Ascend. The screen described the Appellant's current ADL needs as requiring supervision with bathing and eating/feeding. He required no assistance with his IADLs. Based on this information Ascend granted a 60-day short term approval for NF LOC to expire on [redacted], 2020. (Hearing Summary)

6. On [redacted] 2020, [redacted] submitted another Nursing Facility ("NF") Level of Care ("LOC") evaluation form to Ascend. The screen described the Appellant's current Activities of Daily Living ("ADL") needs as requiring supervision

with bathing. He required no assistance with his IADLs. Based on this information the Appellant required a Medical doctor Review. (Hearing Summary)

7. On [redacted], 2020, Ascend's medical doctor reviewed NFLOC screen Medical On-site assessment, Practitioner Certification, Progress Notes, Nurse's Notes, Physician order, Urinary Incontinence Evaluation, Interdisciplinary Rehabilitation Screening, Blood Glucose Monitoring, Minimum Data Set, Face Sheet, and Resident Flow Sheet, and determined that nursing facility level of care is not medically necessary for the Appellant because it is not clinically appropriate in terms of the level of care of services provided and is not considered effective for his condition. The Appellant does not require continuous and intensive nursing care as provided at the nursing facility level. His needs could be met through a combination of medical and psychiatric follow up as well as social services provided outside of the nursing setting. (Hearing Summary, Exhibit 5: Notice of Action)

8. The Appellant is independent in all of the ADL's. He does not require hands-on assistance with bathing, dressing, eating, toileting, continence, transferring or mobility (Exhibit 6: Level of Care Determination Form)

9. [redacted] provides setups for all of the Appellant's medications and meals per facility policy. (Exhibit 6: CT LTC Level of Care Determination Form, Appellant's testimony)

10. The Appellant is not currently receiving occupational, or physical therapy services or other MD ordered services. (Appellant's testimony, Social Worker Testimony).

11. 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 Appellant requested an administrative hearing on [redacted], 2020. This decision, therefore, was due no later than [redacted] 2020. However, the timeframe to render a final decision is extended from 90 to "not later than 120 days" per Department of Social Service's Commissioner's order dated [redacted]/20. (Hearing Record)

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).

4. 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.

5. Ascend correctly used clinical criteria and guidelines solely as screening tools.

6. Ascend correctly determined that the Appellant is independent with all of his ADLs.

7. Ascend correctly determined that the Appellant does not have a chronic medical condition requiring substantial assistance with personal care daily.

8. Ascend correctly determined that the Appellant does not have uncontrolled and/or unstable medical conditions requiring continuous skilled nursing services and /or nursing supervision.

9. Ascend correctly determined it is not clinically appropriate in terms of the level of services and considered effective for the individual's illness, injury, or disease; that the Appellant resides in a nursing facility long term.

10. Ascend correctly determined that long term nursing facility services are not medically necessary for the Appellant, because his medical needs could be met with less costly services offered in the community, 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.

DISCUSSION

The evidence and testimony reflect that although the Appellant does have medical issues, he does not require hands-on assistance with his ADLs and therefore does not have justification for continued long term care approval.

DECISION

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

Swati Sehgal
Hearing Officer

Pc: hearings.commops@ct.gov
Angela Gagen, Ascend Management Innovations/Maximus
Paul Cook, Ascend Management Innovations/Maximus
Connie Tanner, Ascend Management Innovations/Maximus
Jaimie Feril, Ascend Management Innovations/Maximus

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.