STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3730

[redacted], 2021
SIGNATURE CONFIRMATION

[redacted]
[redacted]
Request # 164124

NOTICE OF DECISION
PARTY

[redacted]
[redacted]
[redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

[redacted], 2020, Ascend Management Innovations LLC, ("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 nursing home level of care ("LOC") for [redacted] (the "Applicant") stating that she does not meet the nursing facility level of care criteria.

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

[redacted], 2020, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling an administrative hearing for [redacted] 2020. The hearing was scheduled to be held telephonically due to the COVID-19 pandemic.

[redacted], 2020, OLCRAH issued a notice rescheduling the administrative hearing for [redacted], 2020.

[redacted], 2021, OLCRAH issued a notice rescheduling the administrative hearing for [redacted] 2021.

[redacted], 2021, 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 hearing was held telephonically with no objection from any of the parties. The following individuals were present at the hearing:

[redacted], the Appellant and Applicant's Conservator
Janice Ricciuti, Community Nurse Coordinator, Alternate Care Unit, DSS
Paul Cook, RN, Clinical Reviewer, ASCEND
Veronica King, Hearing Officer

The Hearing record remained open for submission of additional document. On [redacted], 2021, the record closed.

STATEMENT OF THE ISSUE

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

FINDINGS OF FACT

1. [redacted], 2020, the Applicant was admitted to [redacted] Hospital with diagnoses of Acute Metabolic Encephalopathy. [redacted] Hospital submitted a request for Level I exempted hospital discharge screen on [redacted] 2020. The Applicant received a we based 30 day exempted hospital discharge and was admitted to [redacted] [redacted] (the "Facility"), on [redacted] 2020. (Exhibit 2: Hearing Summary and Activities of Daily Living ("ADL") definition and Hearing Record)

2. [redacted], 2020, the Facility submitted the Nursing Facility Level of Care ("NF LOC") screening form to Ascend. The NF LOC screen stated that for current ADLs the Applicant required supervision with bathing, dressing, eating, and mobility. For Instrumental Activities of Daily Living ("IADL"), the Applicant required continual supervision or physical assistance with meal preparation. Based upon the information provided, a Medical Doctor review was needed. (Exhibit 2 and Hearing Record)

3. [redacted] 2020, Bill M. Regan, MD, an Ascend Medical Doctor reviewed all available information relating to the Applicant's medical and total needs to determine if nursing placement was medically necessary. The Applicant has the primary psychiatric diagnoses of Schizoaffective Disorder and he determined that her psychiatric symptom appears stable at this time. During this review, it was noted that the Applicant was independent with all her ADLs and that her needs could be met in a less restrictive setting. The Applicant's needs could be met through the combination of medical, psychiatric, and social services

delivered outside of the Nursing Facility setting. She was noted to be able to complete ADL's without assistance. (Exhibit 4: NF LOC)

4. [redacted], 2020, Ascent sent the Appellant a NOA denying LOC stating that nursing facility services are not medically necessary for the Applicant as she currently does not require the continuous and intensive nursing care as provide at the nursing facility. The NOA also stated that the date of action becomes effective on [redacted] 2020. (Exhibit 3: Notice of Action, [redacted]/20)

5. The Applicant is [redacted] old (DOB [redacted] and a Medicaid recipient. (Exhibit 4)

6. [redacted], 2020, the Appellant requested a hearing to contest the Ascend' s decision to deny LOC for the Applicant. The Appellant stated that she was looking for placement at a lower level of care residence for the Applicant. (Exhibit 1: Hearing Request and Court of Probate Conservatorship)

7. The Applicant currently is noted to have her medical conditions stabilized. (Hearing Record)

8. [redacted], 2020, the Applicant was not attending any rehabilitative therapy services. (Appellant's testimony and Hearing Record)

9. The Applicant is able to complete all of her ADL's independently. (Appellant's Testimony and Hearing Record)

10. [redacted], 2021, the Applicant moved to [redacted] Residential Care Home, a lower level care placement. (Appellant's Testimony)

11. The Appellant agrees with the Department that on [redacted], 2020, the Applicant condition had improved, and she did not need nursing facility level of care. (Appellant's Testimony)

12. It is not clear when Medicaid stopped payments for Long term care services for the Applicant. (Hearing Record)

13. The record was left open for the Appellant submit information regarding Medicaid payments to the Facility. The record closed on [redacted] 2021, and no information was submitted. (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. "The Department shall pay a provider only when the department has authorized payment for the client's admission to that nursing facility." Conn. Agencies Regs. Section 17b-262-707(b).

4. 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 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.

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

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

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

9. Ascend correctly determined that continuous skilled nursing services are not clinically appropriate in terms of type and frequency with respect to treatment of the Applicant's medical conditions.

10. Ascend correctly determined that nursing facility services are not medically necessary for the Applicant, because her medical needs could be met with services offered in a less restrictive setting.

11. Ascend correctly determined that it is not medically necessary for the Applicant to reside in a skilled nursing facility and on [redacted] 2020, correctly denied her request for continued approval of long-term care Medicaid.

DECISION

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

Veronica King
_____
Veronica King
Hearing Officer

Cc: hearings.commops@ct.gov ; Community Options Unit, DSS
AscendCTadminhearings@maximus.com; 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.

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.