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

Case ID # [redacted]
Client ID # [redacted]
Request # 173641

NOTICE OF DECISION
PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2021, Ascend Management Innovations LLC/Maximus, ("Ascend"), the Department of Social Services contractor that administers approval of nursing home care, sent [redacted] (the "Appellant") a notice of action denying nursing facility ("NF") level of care ("LOC") after [redacted] 2021.

On [redacted] 2021, the Appellant's Conservator of Person, [redacted], requested an administrative hearing to contest Ascend's decision to deny nursing home LOC after [redacted] 2021.

On [redacted] 2021, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2021.

On [redacted] 2021, in accordance with sections 17b-60, 17-61, and 4-176e to 4-184 inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing by telephonic conferencing.

The following individuals participated in the hearing:

[redacted] Appellant's Conservator of Person
[redacted] Appellant's Conservator of Person
[redacted] Vice President Psychosocial Services [redacted]
[redacted] Behavioral Program Director, [redacted]
Charles Bryan, Community Options, DSS
Paul Cook, Ascend/Maximus

Jean Benton, Ascend/Maximus
Christopher Turner, Hearing Officer

The Appellant did not participate in the hearing due to his institutionalization.

STATEMENT OF THE ISSUE

The issue is whether Ascend's issuance of a 180 day time-limited approval for nursing facility LOC expiring [redacted] 2021, for the Appellant was correct.

FINDINGS OF FACT

1. On [redacted] 2019, the Appellant was admitted to [redacted] a skilled nursing facility with a [redacted]. (Hearing summary)

2. On [redacted] 2021, [redacted] submitted an NF LOC referral. The NF LOC screen described the individual's current Activities of Daily Living (ADL's) support needs as follows: The Appellant required supervision with bathing, dressing, eating, feeding, mobility and transfers. For Instrumental Activities of Daily Living (IADL's), the Appellant required assistance with meal preparation and verbal or gestural assistance with medications. (Exhibit 6: LOC determination form; Hearing summary)

3. On [redacted] 2021, an ASCEND representative reviewed the completed LOC Determination form and referred the Appellant's case for a Level II review. (Hearing summary)

4. On [redacted] 2021, an onsite Level II assessment or Preadmission Screening and Resident Review ("PASRR") of the Appellant and his medical condition was completed by ASCEND. The Appellant was found to be independent with all of his ADL's and that his needs could be met with community supports including assistance with medication administration. (Exhibit 6)

5. On [redacted], 2021, Ascend issued a notice of action to the Appellant indicating he has been granted a short-term approval without specialized services. The notice indicated the Appellant will not be eligible for Medicaid-funded nursing facility services after [redacted] 2021 without a new authorization request. (Exhibit 5: Notice)

6. On [redacted] 2021, the Department received the Appellant's hearing request. (Record)

7. The Appellant is [redacted] years old (DOB [redacted]) and a Medicaid recipient. (Exhibit 6; Conservator's testimony)

8. The Appellant lived at home alone in [redacted] before his admission to the facility. (Representative's testimony)

9. The Appellant resides in the [redacted] unit part of the facility. The Appellant's typical day includes reading, writing, and watching television. The Appellant is allowed a twice-daily smoking break. (Facilities testimony)

10. The Appellant is independent with his ADLs including dressing, eating, toileting, continence, transferring, and mobility. The Appellant is not in receipt of physical therapy services. (Exhibit 6; Exhibit 11: ADL assistance/supports; Facilities testimony)

11. The Appellant needs some assistance with medication management. (Exhibit 6)

12. The Appellant's current prescription medications are the same as the time of admission and include the following: [redacted] (Exhibit 6; Exhibit 14: Physician orders; Facility testimony)

13. There was no evidence submitted by the facility or the Appellant's representatives to support their position that the Appellant needs constant and continuous care for a chronic condition equal to that of a nursing home level. (Record)

14. The Appellant's condition is evaluated every quarter or three months to determine his potential return to the community. ([redacted] testimony)

15. The issuance of this decision is timely under Connecticut General Statutes ("Conn. Gen. Stat.") 17b-61(a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The Appellant's representative requested an administrative hearing on [redacted] 2021. Therefore, this decision is due no later than [redacted] 2021.

CONCLUSIONS OF LAW

1. Conn. Gen. Stat. § 17b-2 provides the Department of Social Services is designated as the state agency for the administration of (6) the Medicaid program pursuant to Title XIX of the Social Security Act.

2. Regulations of Connecticut State Agencies ("Regs., Conn. State Agencies") § 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. 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 a mental illness or mental retardation as identified by the *preadmission MI/MR screen*.

Regs., Conn. State Agencies §17b-262-707(b) provides the Department shall pay a provider only when the department has authorized payment for the client's admission to that nursing facility.

The Appellant is a resident of a long-term care facility authorized to receive payment for nursing facility services.

3. Title 42 of the Code of Federal Regulations ("C.F.R") § 483.128 (a) provides the State's PASRR program must identify all individuals who are suspected of having MI or IID as defined in §483.102. This identification function is termed Level I. Level II is the function of evaluating and determining whether NF services and specialized services are needed. The State's performance of the Level I identification function must provide at least, in the case of first-time identifications, for the issuance of written notice to the individual or resident and his or her legal representative that the individual or resident is suspected of having MI or IID and is being referred to the State mental health or intellectual disability authority for Level II screening.

   42 C.F.R. § 483.132 (a) provides that for each applicant for admission to a NF and each NF resident who has MI or IID, the evaluator must assess whether: (1) The individual's total needs are such that his or her needs can be met in an appropriate community setting; (2) The individual's total needs are such that they can be met only on an inpatient basis, which may include the option of placement in a home and community-based services waiver program, but for which the inpatient care would be required; (3) If inpatient care is appropriate and desired, the NF is an appropriate institutional setting for meeting those needs in accordance with §483.126; or; (4) If the inpatient care is appropriate and desired but the NF is not the appropriate setting for meeting the individual's needs in accordance with §483.126, another setting such as an ICF/IID (including small, community-based facilities), an IMD providing services to individuals aged 65 or older, or a psychiatric hospital is an appropriate institutional setting for meeting those needs.

   42 C.F.R. § 483.132 (b) provides for *Determining appropriate placement.* In determining appropriate placement, the evaluator must prioritize the physical and mental needs of the individual being evaluated, taking into account the severity of each condition.

42 C.F.R. § 483.132 (c) provides at a minimum, the data relied on to make a determination must include: (1) Evaluation of physical status (for example, diagnoses, date of onset, medical history, and prognosis); (2) Evaluation of mental status (for example, diagnoses, date of onset, medical history, likelihood that the individual may be a danger to himself/herself or others); and (3) Functional assessment (activities of daily living)

ASCEND properly completed a Level I and Level II evaluations of the Appellant per Federal regulations.

Ascend's PASRR review of the Appellant's medical condition shows the Appellant not needing any supports with his ADL's.

4. Conn. Gen. Stat. § 17b-259b provides (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.

   42 C.F.R. § 440.230 provides for sufficiency of amount, duration, and scope. (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

The Appellant does not have uncontrolled and/or unstable conditions requiring continuous skilled nursing services and/or nursing services on a daily basis.

The Appellant has the physical ability to complete his ADL's. He does not need substantial assistance with personal care on a daily basis including eating, toileting, bathing, eating, transferring, mobility and dressing.

Ascend is correct in its determination that the Appellant does not meet the medically necessary criteria for a nursing facility level of care beyond [redacted] 2021.

DISCUSSION

It is more likely than not, based on the Appellant's current medical condition, both mental and physical, the Appellant does not have an uncontrolled and/or unstable conditions requiring continuous skilled nursing services and/or nursing supervision requiring substantial assistance with personal care on a daily basis. As it is anticipated the Appellant's medical needs could be met with services provided in a community setting, Ascend's decision to terminate the Appellant's NF LOC approval on [redacted] 2021, is upheld. The facility may submit another LOC request closer to the end date if they feel it necessary.

DECISION

The Appellant's appeal is denied.

Christopher Turner
Hearing Officer

Cc: hearings.commonops@ct.gov
AscendCTadminhearings@maximus.com
Charles Bryan, Community Options Unit, Department of Social Services
[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, law, and 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 the 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 the 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 if 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, 165 Capitol Avenue, 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 to 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 following §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.