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

[redacted] 2021
Signature Confirmation

Client ID [redacted]
Case ID [redacted]
Request # 176911

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2021, Ascend Management Innovations, LLC, ("Ascend) the Department of Social Services' (the "Department") vendor that administers approval of nursing home care, sent [redacted] (the "Appellant") a notice stating that nursing facility level of care ("LOC") is not medically necessary because it is not considered effective for you and is not clinically appropriate in terms of level.

On [redacted] 2021, the Appellant requested an administrative hearing to contest Ascend's decision to deny nursing facility LOC.

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, the Appellant requested a continuance which OLCRAH granted.

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

On [redacted] 2021, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing via teleconference.

The following individuals called in for the hearing:

[redacted], Appellant
[redacted], Social Worker, [redacted]
Jean Denton, LPN, Ascend Representative
Allison Weingart, Community Nurse Coordinator, Department Representative
Lisa Nyren, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Ascend's [redacted] 2021 decision to deny the nursing facility's [redacted] 2021 request for a LOC determination on behalf of the Appellant as not medically necessary was correct.

FINDINGS OF FACT

1. On [redacted] 2020 [redacted] (the "facility"), a skilled nursing facility, admitted the Appellant, date of birth [redacted], to their facility. (Hearing Record)

2. The Appellant's admitting diagnosis was endocarditis, B/L Septic PE Emboli, NDA, Opioid Dependance, IVDA, History of depression, Right Knee Septic Arthritis, Polysubstance Abuse, Non Unresolved Hepatitis C, Sepsis due to recurrent Tricuspid Valve Endocarditis, with evidence of Cord Rupture, Thoracic Discitis without Mucositis, Sacralities, Hemoptysis, non-mass due to Septic Emboli, Thrombocytopenia due to infection, Acute right low back pain without sciatica, Cocaine use, Nicotine use, Paroxysmal Tachycardia, and Myositis. (Exhibit 3: Hearing Summary and Exhibit 6: LOC Determination Form)

3. Ascend is the Department's contractor that determines if a patient meets the nursing home LOC criteria to authorize Medicaid payment. (Hearing Record)

4. On [redacted] 2020, the facility requested a LOC determination for the Appellant's stay at the facility. Ascend determined the Appellant met LOC criteria and authorized a short-term approval of 60 days for the Appellant's stay at the facility which expired on [redacted], 2020. (Exhibit 3: Hearing Summary)

5. On [redacted] 2020, the facility requested a LOC determination for the Appellant's stay at the facility. Ascend determined the Appellant met LOC criteria and authorized a short-term approval of 60 days for the Appellant's stay at the facility which expired on [redacted] 2020. (Exhibit 3: Hearing Summary)

6. On [redacted] 2020, the facility requested a LOC determination for the Appellant's stay at the facility. Ascend determined the Appellant met LOC criteria and authorized a short-term approval of 90 days for the Appellant's stay at the facility which expired on [redacted] 2020. (Exhibit 3: Hearing Summary)

7. On [redacted] 2020, the facility requested a LOC determination for the Appellant's stay at the facility. Ascend determined the Appellant met LOC criteria and authorized a short-term approval of 60 days for the Appellant's stay at the facility which expired on [redacted] 2020. (Exhibit 3: Hearing Summary)

8. On [redacted] 2020, the facility requested a LOC determination for the Appellant's stay at the facility. Ascend determined the Appellant met LOC criteria and authorized a short-term approval of 60 days for the Appellant's stay at the facility which expired on [redacted] 2020. (Exhibit 3: Hearing Summary)

9. On [redacted] 2021, the facility requested a LOC determination for the Appellant's stay at the facility. Ascend determined the Appellant met LOC criteria and authorized a short-term approval of 90 days for the Appellant's stay at the facility which expired on [redacted] 2021. (Exhibit 3: Hearing Summary)

10. On [redacted] 2021 [redacted] completed the Practitioner Certification attesting the Appellant meets nursing home LOC. (Exhibit 7: Practitioner Certification)

11. On [redacted] 2021, the facility submitted the Connecticut Level of Care Form ("LOC form") and supporting documents to Ascend requesting a LOC approval for a short-term stay of 31 - 60 days on behalf of the Appellant. The facility lists the related skilled nursing service as: monitor of medical status, lab work, and changes in vitals and medical presentation. The facility lists the medical diagnosis which require nursing services as: sepsis; staphylococcal arthritis, hepatitis c, and anxiety disorder. The facility writes, "requires medication management and administration due to comorbidities. See MD orders." The facility notes the Appellant is "independent or supervision < daily" under the following Activities of Daily Living ("ADL"): bathing, dressing, eating/feeding, toileting, mobility, transfer and continence. The LOC form defines

independent or supervision < daily as "requires no assistance or supervision. If assistive devices are used, needs no monitoring, assistance, or supervision to use those devices." The facility lists the Appellant "fully orientated and needs no prompting or cueing" for the following categories: self (awareness of own name), place (awareness of current location), time (awareness of current date and time), situation (awareness of current situation). The facility notes no problems indicated for memory, judgement, communication, vision, and behaviors associated with dementia. The Appellant is capable of preparing meals with minimal assistance. The facility notes no evidence of worsening anxiety or depression with her treatment plan as continue current medication. (Exhibit 6: LOC Determination Form, Exhibit 9: Minimum Data Set, and Exhibit 12: Physician's Orders)

12. Ascend completed a review of the facility's request for a LOC determination on behalf of the Appellant using the following documents provided by the facility: the [redacted] 2021 LOC form and supporting documents which included the Practitioner Certification, Face Sheet, and Minimum Data Set, the Resident Flow Sheet for [redacted] 2021, Physician's Order [redacted] 2021, Progress Notes [redacted] 2021, and Psychiatry Progress Notes [redacted] 2021. Ascend determined the Appellant did not meet nursing facility LOC criteria. Ascend determined nursing facility LOC is not medically necessary for the Appellant because she does not require the continuous nursing services delivered at the level of the nursing facility. Ascend determined the Appellant's needs could be met in a less restrictive setting. (Hearing Record)

13. On [redacted] 2021, , Ascend issued a notice of action to the Appellant. The notice stated Ascend determined that "nursing facility level of care is not medically necessary for you at this time. ... Based on a comprehensive assessment of you and your medical condition, that nursing facility level of care is not medically necessary because it is not considered effective for you and is not clinically appropriate in terms of level." (Exhibit 5: Notice of Action)

14. The Appellant is independent with most activities of daily living ("ADL's") and instrumental activities of daily living ("IADL's"). The Appellant requires no assistance with maintaining proper hygiene. The Appellant is capable of bathing/showering independently, dressing independently, and toileting on her own without assistance. Although the Appellant is able to walk independently without any assistive devices, her endurance is compromised limited to six minutes of continual walking. The Appellant has a hard time breathing after walking more than six minutes. The Appellant requires assistance with medication management with set ups two times per day and meal preparation to ensure she remains on a low

fat, low salt diet. (Appellant's Testimony and Facility Representative's Testimony)

15. The Appellant received physical therapy in 2020 ending in [redacted] 2020. The Appellant resumed physical therapy from [redacted] 2021 through [redacted] 2021 to increase her endurance level since her heart valve replacement surgery in 2020. The Appellant is scheduled for a physical therapy reassessment in [redacted] 2021. Physical therapy did not provide the Appellant with exercises upon discharge on [redacted] 2021. (Appellant's Testimony and Facility Representative's Testimony)

16. Currently the facility monitors and tracks the Appellant's heart health and edema (fluid retention) through routine vital checks measuring the Appellant's blood pressure, oxygen level, and breathing rate, and through weekly blood tests. (Appellant's Testimony and Facility Representative's Testimony)

17. The Appellant wishes to extend her stay at the facility because she has not located appropriate housing. The Appellant is working with Money Follows the Person ("MFP") to locate suitable housing in the community. In addition, the Appellant wishes to continue to build her endurance when walking and continue regular monitoring of her medical condition through vitals, blood work, and physical therapy at the facility. (Appellant's Testimony)

18. 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] 2021. However, the hearing, which was originally scheduled for [redacted] 2021 was rescheduled for [redacted] 2021 at the request of the Appellant, which cause a [redacted]-day delay. Because this [redacted]-day delay resulted from the Appellant's request, this decision is not due until [redacted] 2021 and therefore, timely.

CONCLUSIONS OF LAW

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

2. Section 17b-262-707(a) of the Regulations of Connecticut State Agencies ("Regs., Conn. State Agencies") provides as follows:

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.

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

4. State regulation provides as follows:

   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 person care, on a daily basis.

   Regs., Conn. State Agencies § 19-13-D8t(d)(1)(A)(i)

5. State statute provides as follows:

   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.

Conn. Gen. Stats. § 17b-259b(a)

6. State Statute provides as follows:

Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medically necessity of a required health service shall be 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.

Conn. Gen. Stat. § 17b-259b(b)

7. State Statute provides as follows:

The Department of Social Services shall amend or repeal any definitions in the regulations of Connecticut state agencies that are inconsistent with the definition of medical necessity provided in subsection (a) of this section, including the definitions of medical appropriateness and medically appropriate, that are used in administering the department's medical assistance program. The commissioner shall implement policies and procedures to carry out the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal not later than twenty days after implementation. Such policies and procedures shall be valid until the time the final regulations are adopted.

Conn. Gen. Stat. § 17b-259b(d)

8. “The department shall review the medical appropriateness and medical necessity of medical goods and services provided to Medical Assistance Program clients both before and after making payment for such good and services.” Regs., Conn. State Agencies § 17b-262-527

9. State regulation provides as follows:

   Prior authorization, to determine medical appropriateness and medical necessity, shall be required as a condition of payment for certain Medical Assistance Program goods or services as set forth in the regulations of the department governing specific provider types and specialties. The department shall not make payment for such goods and services when such authorization is not obtained by the provider of the goods or services.

   Regs., Conn. State Agencies. §17b-262-528(a)

10. “Prior authorization shall be granted by the department to a provider to furnish specified goods or services within a defined time period as set forth in the regulations of the department governing specific provider types and specialties.” Regs., Conn. State Agencies § 17b-262-528(b)

11. State regulation provides as follows:

    In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

    Regs. Conn. State Agencies § 17b-262-528(d)

12. State statute provides as follows:

    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.

    Conn. Gen. Stat. § 17b-259b(c)

13. **Ascend correctly determined the Appellant does not require continuous skilled nursing services for an uncontrolled or unstable condition or supervision for a chronic condition requiring substantial assistance on a daily basis. The Appellant's health has improved since her admission in [redacted] 2020 and does not require continuous skilled nursing services. The Appellant does not require substantial assistance on a daily basis but does require minimal assistance with medication management and meal preparation which can be provided in the community. Although the Appellant is waiting on a physical therapy evaluation, this also can be provided in the community where she may continue to work on her endurance level. Although the facility provides regular monitoring of the Appellant's vitals and conducts routine weekly blood tests, vital checks and blood testing can also be provided in the community through outpatient services.**

    Ascend was correct in its determination that the Appellant does not meet the medical criteria for nursing home level of care.

    Ascend correctly denied the facility's request for LOC review on behalf of the Appellant as not medically necessary, as defined by section 17b-259b(a) of the Connecticut General Statute.

    On [redacted] 2021, Ascend correctly issued the Appellant a Notice of Action informing her that the request for authorization of services based on medical necessity was denied.

DECISION

The Appellant's appeal is denied.

Lisa A. Nyren
Fair Hearing Officer

CC: DSS Community Options Division
AscendCTadminhearings@maximus.com

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, 165 Capitol Avenue, 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.