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

[redacted] **2022**
Signature Confirmation

Case ID # [redacted]
Client ID # [redacted]
Request # 183086

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2021, Ascend Management Innovations LLC, ("Ascend"), the Department of Social Services (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 stating that she does not meet the nursing facility level of care criteria.

On [redacted] 2021, the Appellant requested an administrative hearing to contest Ascend's decision to deny nursing home level of care.

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] 2022, Appellant requested a re-schedule and it was granted.

On [redacted] 2022, OLCRAH issued a notice rescheduling the administrative hearing for [redacted] 2022.

On [redacted] 2022, 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 for the hearing:

[redacted], Appellant
[redacted], Social Worker, [redacted]
Jean Denton, Clinical Supervisor, Ascend Management Innovations
Almelinda McLeod, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Ascend's decision that the Appellant does not meet the level of care requirements for a nursing facility was correct.

FINDINGS OF FACT

1. The Appellant is [redacted] years old (DOB- [redacted]) and currently a Husky D low-income Adult Medicaid recipient of long-term care support services. (Hearing record and Exhibit 6: Level of Care Determination Form dated [redacted] 2021)

2. On [redacted] 2021, the Appellant was admitted to [redacted], a skilled nursing facility ("the facility") from [redacted] Hospital under a 30-day exempted hospital discharge ("EHD"); which expired [redacted] 2021. (Hearing summary)

3. An EHD is when the hospital believes the Appellant can recover from a condition she was treated for while in the hospital, within 30 days in a facility. (Hearing record)

4. The Appellant had diagnosis of hypertension, Anasarca, obstructed sleep apnea, bilateral lower extremity weakness and hypothyroidism. (Hearing record)

5. The Appellant' stay in the facility exceeded the 30 days. Subsequent Nursing Facility Level of Care ("NFLOC") screening forms were sent to Ascend from [redacted] 2021, to [redacted] 2021, however, information needed to complete the reviews were not received and resulted in technical denials. (Hearing record)

6. On [redacted] 2021, the facility submitted the NFLOC screening form to Ascend. The Appellant was noted as hands on bathing and supervision with dressing. For IADL support needs include medication management and meal preparation. The Appellant was fully alert and orientated to self, place, and time. Based on this report, the Appellant required a Medical Doctor review. (Hearing Record, Exhibit 6, LOC) (Exhibit 6, LOC determination)

7. The Appellant takes the following medications: Acetaminophen, Ammonium Lactate, Artificial tears, Ayr Nasal spray, Cetirizine HCl, Dulcolax, Fleet enema, Fluticasone Propionate Suspension, Gabapentin, Lasix, Lisinopril, Loratadine,

Melatonin, Milk of Magnesia, Mira-Lax, Motrin, Protonix, Sertraline, Simethicone and Synthroid. (Exhibit 11, order summary report)

8. The Appellant is not currently receiving physical or occupational therapy services. The hearing record shows the Appellant received Physical therapy and Occupational therapy starting on [redacted] 2021, and ending on [redacted] 2021, when goals were successfully met. (Hearing record, Exhibit 9, Physical therapy discharge summary and Exhibit 10, Occupational therapy discharge summary)

9. On [redacted] 2021, Ascend's medical doctor, Bill Regan, MD reviewed all available information [NFLOC, Practitioner screen, Psychological Progress Notes, Occupational and Physical Therapy treatment notes] and determined the Appellant does not meet medical necessity criteria. With only IADL medical management services provided, the Appellant does not require the continuous nursing services delivered at the level of a nursing facility. The Appellant will be able to get her needs met through a less restrictive setting with the combination of medical, psychiatric, and social services outside of the facility. She will need intermittent assistance through home health, visiting nurse of some other venue to monitor her condition. (Hearing Summary, Exhibit 6, LOC)

10. On [redacted] 2021, Ascend issued a Notice of Action, Denial of Nursing facility Level of Care as it is not considered effective and not clinically appropriate in terms of level and thus nursing facility level of care is not medically necessary. (Exhibit 5: NOA)

11. The Appellant requires help washing her back and hair and can handle most of her dressing, however, needs helps putting on her sock and shoes because she cannot bend down nor bend her knee. The Appellant cannot be in public by herself as she needs assistance with her mobility. She does have a rolling walker which is helpful. Although independent with toileting and continence she needs to be close to a bathroom. (Appellant's testimony)

12. In [redacted] 2021, the Appellant applied for Money follows the Person ("MFP") and currently has a case manager working with her while active on Medicaid. The Appellant requires proper housing for her physical limitations and appropriate housing for her children, who are not living with her given her present situation. (Appellant testimony)

13. 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. The Appellant requested a re-schedule delaying the closing of this hearing record by 51 days; therefore, this decision is due not later than [redacted] 2022, 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. Conn Agencies Regs. § 19-13-D 8 t (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.”

3. Conn. Agencies Regs. 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. 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.”

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.

Ascend correctly used clinical and guidelines solely as screening tools.

Ascend correctly determined that based on the evidence, the Appellant does not have uncontrolled and/or unstable conditions requiring nursing services.

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

Ascend correctly determined that it is not clinically appropriate in terms of level that the Appellant reside in a skilled nursing facility.

Ascend correctly determined that it is not medically necessary for the Appellant to reside in a skilled nursing facility, because her needs could be met in a less restrictive setting with a combination of medical, psychiatric and social services where intermittent assistance through home health, visiting nurse or some other venue to monitor her condition.

DECISION

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

Almelinda McLeod
Almelinda McLeod
Hearing Officer

CC: hearings.commops@ct.gov
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 06105-3725.

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, 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.