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

[redacted]**3, 2022**
Signature Confirmation

Client ID # [redacted]
Case ID # [redacted]
Request # 186890

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2021, Ascend Management Innovations LLC, ("Ascend"), the contractor that administers approval of nursing home care for the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA") denying nursing home level of care stating that he 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] 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 at the hearing:

[redacted], Appellant
[redacted], Director of Social Work, [redacted]
Janice Ricciuti, RN, Department's Representative
Jean Denton, Nurse, Ascend Management Innovations
Scott Zuckerman, 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 53 years old (DOB [redacted]/1968) and a Medicaid recipient of long term care support services. (Hearing record and Exhibit 8: Level of Care Form dated [redacted] 2021)

2. On [redacted] 2021, the Appellant was admitted to [redacted] with a diagnosis of acute exacerbation of chronic low back pain, and abscess in epidural space of lumbar spine. (Hearing Summary)

3. On [redacted], 2021, [redacted] submitted the Nursing Facility Level of Care ("NFLOC") screening to Ascend. The LOC form described the Appellant's current Activities of Daily Living ("ADLs") support needs as: The Appellant required hands on assistance with bathing, dressing, toileting, mobility, transfers, and continence. For Instrumental Activities of Daily Living ("IADL"), the Appellant required minimal assistance with meal preparation and no assistance with medication. (Hearing Summary)

4. On [redacted], 2021, the Appellant was admitted to [redacted] (the "facility") from [redacted] for a 90-day short term approval with an end date of [redacted] 2021. (Hearing Summary)

5. On [redacted], 2021, the facility submitted the NFLOC form to Ascend. The NFLOC form described the Appellant's ADL support needs that he required supervision with transfers. For his IADLs he required minimal assistance with meal preparation and verbal assistance with medication. (Hearing Summary)

6. On [redacted], 2021, Ascend's medical doctor reviewed all of the information submitted for the [redacted], 2021 LOC submission and determined the Appellant is able to complete all ADL's without assistance. There were no therapies or skilled nursing services other than verbal assistance in medication support. The doctor determined the Appellant does not require nursing facility level of care because it is not medically necessary. It was not clinically appropriate in terms of the level of services provided and not effective for his condition. The Appellant's needs could be met through the combination of medical, psychiatric, and social services outside of the nursing facility setting. (Hearing Summary, Exhibit 8: Level of Care Form, [redacted]/2021, Exhibit 10: Point of Care History)

7. The Appellant is independent with his ADLs including dressing, eating, toileting, continence, transferring and mobility. At the time of Ascend's review, the Appellant required no rehabilitative services, medication supports. (Hearing Summary, Exhibit 6: Level of Care report)

8. On [redacted], 2021, Ascend issued a Notice of Action to the Appellant denying Nursing facility level of care. The notice stated that the Appellant does not require continuous nursing services delivered at the level of the nursing facility and as a result you are not eligible for Medicaid coverage of nursing facility services effective [redacted], 2021. (Exhibit 7: NOA, [redacted]/2021)

9. On [redacted], 2022, OLCRAH received the Appellant's hearing request form. (Hearing Record)

10. The Appellant is independent in all his ADL's. The Appellant is not receiving Physical Therapy ("PT"), Occupational Therapy ("OT") or Speech Therapy. The Appellant receives medication administration at the facility. (Appellant's testimony, Facility's representative's testimony, and Exhibit 11: Continuity of Care Document)

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

12. 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. Therefore, this decision is due not later than [redacted], 2022, and is therefore timely. (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:

(a) 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."

(ii) That a patient admitted to a rest home with nursing supervision has controlled and/or stable chronic conditions which require minimal skilled nursing services, nursing supervision, or 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 Statutes 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.

The Appellant does not have uncontrolled and/or unstable conditions requiring nursing services.

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

It is not clinically appropriate that the Appellant reside in a nursing facility.

Ascend Management Innovations is correct in its determination that the Appellant does not meet the medically necessary criteria for a nursing facility level of care.

Ascend Management Innovations correctly determined that it is not medically necessary for the Appellant to reside in a skilled nursing facility.

DECISION

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

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Scott Zuckerman
Scott Zuckerman
Hearing Officer

Pc: 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.

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.