

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

██████████, 2022  
SIGNATURE CONFIRMATION

CASE # ██████████  
CLIENT ID # ██████████  
REQUEST# ██████████

NOTICE OF DECISION

PARTY

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PROCEDURAL BACKGROUND

On ██████████, 2022, Ascend Management Innovations LLC, (“Ascend”), the Department of Social Services (the “Department”) contractor that administers approval of nursing home care, sent ██████████ (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 ██████████ 2022, the Appellant requested an administrative hearing to contest Ascends decision to deny nursing home level of care.

On ██████████, 2022, the Office of Legal Counsel, Regulations, and Administrative Hearings (“OLCRAH”) issued a notice scheduling the administrative hearing for ██████████ 2022.

On ██████████ 2022, the following individuals participated at the hearing.

- ██████████, Appellant
- ██████████, Appellant’s Conservator
- ██████████, Social Worker, ██████████
- Jean Denton, LPN, Lead Clinical Reviewer, Maximus Company
- Patricia Jackowski, Registered Nurse, Community Options
- Joseph Alexander, Administrative Hearing Officer

**STATEMENT OF THE ISSUE**

The issue to be decided is whether Ascends decision that the Appellant does not meet the criteria for Nursing Facility Level of Care (“NFLOC”) is correct.

**FINDINGS OF FACT**

1. [REDACTED] (the “Conservator”) is the Appellant’s Conservator. (Appellant Testimony, Conservator Testimony)
  
2. The Appellant is [REDACTED] years old (DOB [REDACTED]) and a recipient of Husky D-Medicaid for Low-income Adults. (Ex. 6: Level of Care Determination, Hearing Record)
  
3. On [REDACTED] 2020, the Appellant was admitted to [REDACTED] (“the Facility”) with the following diagnoses: (Ex. 6: Level of Care Determination, Hearing Record)
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  - [REDACTED]
  
4. On [REDACTED], 2020, the Facility submitted the Nursing Facility Level of Care (“NFLOC”) screening form to Ascend. The NFLOC form described the Appellant’s current Activities of Daily Living (“ADL”) support needs as follows. The Appellant required hands on assistance with bathing and toileting and required supervision with dressing, mobility, and transfer. For Instrumental Activities of Daily Living (“IADL”), the Appellant required physical assistance with medications, and continual supervision with meal preparation. Ascend approved the Appellant for a short-term, 150 day stay. The approval expired on [REDACTED], 2021. (Ex. 4: ADL Measures and Ratings, Hearing Record)

5. On [REDACTED], 2021, the Appellant received short-term approval for an additional 180 days. This approval expired on [REDACTED], 2021. (Hearing Record)
6. For the period of [REDACTED], 2021, through [REDACTED], 2022, the Appellant continued to reside in the Facility due to COVID 19 Emergency Declaration Blanket Waivers which prevented nursing facilities from discharging residents. (Hearing Record)
7. On [REDACTED], 2022, the Facility submitted an NFLOC screening form to Ascend. The NFLOC form described the Appellant's ADL support needs as follows. The Appellant required hands on assistance with bathing and supervision with dressing, toileting, mobility and transfer. For IADLs the Appellant required physical assistance with medications and continual supervision with meal preparation. (Ex. 4: ADL Measures and Rating, Hearing Record)
8. On [REDACTED], 2022, an Ascend medical doctor reviewed all available information for the [REDACTED] 2022, NFLOC submission which included the Practitioner Certification, care details and nurses' notes. The doctor concluded that nursing facility level of care was not medically necessary for the Appellant as this care was not clinically appropriate in terms of the level of services provided and was not considered effective for the Appellant's conditions. The Appellant's needs could be met through a combination of medical, psychiatric, and social services delivered outside of the nursing facility setting. The Appellant would need intermittent assistance through home health, visiting nurse or some other venue to monitor his conditions. (Dept. Ex. 6: Level of Care Determination, Ex. 7: Practitioner's Certificate, Ex. 8: Complete Care Details, Ex. 9: Nurses Notes, Hearing Record)
9. On [REDACTED], 2022, 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 effective [REDACTED], 2022, the Appellant is no longer eligible for Medicaid coverage of nursing facility services. (Exhibit 5: Notice of Action)
10. On [REDACTED] 2022, OLCRAH received the Appellant's hearing request form. (Hearing Record)
11. The Appellant is independent in all his ADL's. The Appellant is not receiving Physical Therapy ("PT"), Occupational Therapy ("OT") or Speech Therapy. (Appellant Testimony)

12. The Appellant's current prescribed medications include [REDACTED], [REDACTED] and [REDACTED]. The Appellant has also been instructed to take a [REDACTED] and [REDACTED] which he can obtain over the counter. (Facility Ex. A: Medication List)
13. The Appellant's most recent Physical Therapy was terminated on [REDACTED] 2021. (Social Worker Testimony)
14. The Appellant is working with the Department's "Money Follows the Person" program and is waiting to be placed in a residential setting in the community. (Conservator's Testimony)
15. 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)
16. The issuance of this decision is timely under Connecticut General Statutes 17b-61(a), which requires that a decision be issued within [REDACTED] days of the request for an administrative hearing. The Appellant requested an administrative hearing on [REDACTED] 2022, making this decision due no later than [REDACTED] 2022.

### **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. Conn Agencies Regs. § 19-13-D8t(d)(1)(A) provides that “Patients shall be admitted to the facility only after a physician certifies the following:

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.”

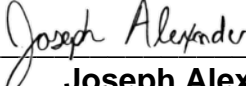
4. Conn. Gen. Stats. § 17b-259b provides for the definition of "Medically necessary" and "Medical necessity" as follows: (a) For purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services 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.

5. **Ascend correctly used clinical criteria and guidelines solely as screening tools.**
6. **Ascend correctly determined that the Appellant does not have a chronic medical condition requiring substantial assistance with personal care.**
7. **Ascend correctly determined that the Appellant does not have uncontrolled and/or unstable medical conditions requiring continuous skilled nursing services and/or nursing supervision.**
8. **Ascend correctly determined that it is not clinically appropriate for the Appellant to reside in a nursing facility.**
9. **Ascend correctly determined that nursing facility services are not medically necessary for the Appellant because his medical needs could be met with services offered in the community.**

### **DECISION**

The Appellant's appeal is **DENIED**

  
\_\_\_\_\_  
**Joseph Alexander**  
**Administrative Hearing Officer**

CC: [hearings.commops@ct.gov](mailto: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 §4-1181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, 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 with 45 days of the mailing of this decision, or 45 days after the agency denies 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 06105-3725. 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 her 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.