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

[redacted] **2023**
Signature Confirmation

[redacted]
[redacted]
[redacted] **204781**

NOTICE OF DECISION

PARTY

[redacted]
[redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2022, Maximus Management Innovations LLC., ("Maximus"), the Department of Social Service's (the "Department") contractor that administers approval of nursing home care, sent [redacted] (the "Appellant"), a Notice of Action ("NOA") denying nursing facility level of care ("NFLOC") indicating that she does not meet the NFLOC criteria.

On [redacted] 2022, the Appellant requested an administrative hearing to contest Maximus' decision to deny Nursing Facility Level of Care.

On [redacted] 2022, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling an administrative hearing for [redacted] 022.

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 participated in the administrative hearing:

[redacted] Appellant's Conservator, via telephone
Alison Weingart, DSS, RN, Community Options
Jean Denton, Maximus Representative, via telephone
[redacted]
Shelley Starr, Hearing Officer

The Appellant was not present at the hearing.

STATEMENT OF THE ISSUE

The issue to be decided is whether Maximus' decision that the Appellant does not meet the criteria for NFLOC is correct.

FINDINGS OF FACT

1. The Appellant is 68 years old [redacted] (Conservator's Testimony; Exhibit 6: Level of Care Form; Hearing Record)

2. On [redacted] 022, the Appellant was admitted to [redacted] from the [redacted], with a primary medical diagnosis of seizure disorder and encephalopathy. She received a 150-day short term approval that expired on [redacted] 2022. (Hearing Summary; Hearing Record)

3. On [redacted] 2022, [redacted] submitted the Nursing Facility Level of Care ("NFLOC") to Maximus. The screening described the Appellant as requiring supervision with bathing, dressing, mobility, and transfer. For Instrumental Activities of Daily Living ("IADLs") the Appellant required verbal assistance with medications, and minimal assistance with meal preparation. Based on this information, a Medical Doctor Review was required. (Hearing Summary; Hearing Record)

4. The ADL Measures include bathing, dressing, eating, toileting, continence, transferring and mobility. (Hearing Summary; Exhibit 4: ADL Measures and Ratings)

5. Maximus reviewed the Appellant's NFLOC screen, Practitioner Certification, Physical Therapy Orders, Occupational Therapy Note, Physical Therapy Note, Documented Survey Report, Order Summary Report, Medication Administration Record, and Progress Note. Maximus's medical doctor concluded that nursing facility level of care is not medically necessary because the Appellant does not require the continuous nursing services delivered at the level of the nursing facility.

Her needs could be met in a less restrictive setting with appropriate supports. (Hearing Summary; Hearing Record)

6. The Doctor Review determined that the Appellant was independent with her activities of daily living including bathing, dressing, eating, toileting, continence, transferring and mobility. Nursing Facility level of care was determined as not clinically appropriate in terms of the level of services provided and is not considered effective for her condition. (Hearing Summary; Exhibit 6: Connecticut Level of Care Form)

7. The Appellant received Physical and Occupational Therapy, which ended i [redacted] 2022. The Appellant is not currently receiving any therapy services at the facility. (Conservator's Testimony; Facility Testimony)

8. The Appellant does not utilize any durable medical equipment. (Conservator's Testimony; Hearing Record)

9. The Appellant is administered approximately 10 medications daily. (Conservator's Testimony; Director of Social Work's Testimony)

10. The Appellant's condition has stabilized and improved since her admission to [redacted]. (Conservator's Testimony; Social Worker's Testimony; Hearing Record)

11. The Appellant is working with the Money Follows the Person Program. (Conservator's Testimony; Hearing Record)

12. The Conservator agrees with the proposed action that the Appellant could discharge from the Nursing Facility to the community with appropriate placement and supports. (Conservator's Testimony)

13. On [redacted] 2022, Maximus issued a notice of action ("NOA") to the Appellant indicating that she does not meet the medical criteria for NFLOC because it is not considered effective for her and is not clinically appropriate in terms of level. Her needs can be met in a less restrictive setting with a combination of medical, psychiatric, and social services delivered outside of the nursing facility. As a result, she is not eligible for Medicaid coverage of nursing facility services. (Exhibit 5: Notice of Action dated, [redacted] 2022; Hearing Record)

14. 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] 2022. Therefore, this decision is due not later than [redacted] 2023.

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes ("Conn. Gen. Stats.") authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.

   Section 17b-261b(a) of the Connecticut General Statutes provides the Department of Social Services shall be the sole agency to determine eligibility for assistance and services under programs operated and administered by said department.

   Section 17b-262 (a)(1) of the Connecticut General Statutes provides the Commissioner of Social Services may make such regulations as are necessary to administer the medical assistance program. Such regulations shall include provisions requiring the Department of Social Services (1) to monitor admissions to nursing home facilities, as defined in section 19a-521.

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 ("Regs., Conn. State Agencies") Section. 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." [Regs., Conn. State Agencies Section 17b-262-707(a)].

3. Regs., Conn. State Agencies § 19-13-D8t(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."

4. 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 who was authorized to receive payment for nursing home services.

5. Title 42 of the Code of Federal Regulations ("C.F.R. ") § 409.31 (b) provides for specific conditions for meeting level of care requirements. (1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis. (2) Those services must be furnished for a condition-(i) For which the beneficiary received impatient hospital or inpatient CAH services; or (ii) Which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital or inpatient CAH services; or (iii) For which, for an M+ C enrollee described in §409.20(c)(4), a physician has determined that a direct admission to a SNF without an inpatient hospital or inpatient CAH stay would be medically appropriate. (3) The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF., on an inpatient basis.

   The Appellant has previously met the NFLOC criteria before the issuance of the [redacted] 2022, notice of action denying such approval.

6. C.F.R. § 483.132(b) provides for determining appropriate placement and states in determining appropriate placement, the evaluator must prioritize the physical and mental needs of the individual being evaluated, considering the severity of each condition.

   C.F.R.§ 483.132 (c) provides at a minimum, the data relied on to decide 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).

   Maximus properly completed an assessment and evaluation of the Appellant per Federal Regulations.

   Maximus' review of the Appellant's medical conditions shows the Appellant is independent with Activities of Daily Living and that she does not need continuous care provided at the nursing facility level of care.

7. Conn. Gen. Stats. § 17b-259b provides the definition of "Medically necessary" and "medical necessity". (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.

8. 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 utilization control procedures.

Maximus correctly determined that the Appellant does not currently have uncontrolled and/or unstable medical conditions requiring continuous skilled nursing services on an everyday basis.

Maximus correctly determined that it is not clinically appropriate for the Appellant to reside in a nursing facility.

Maximus correctly determined that nursing facility services are not medically necessary for the Appellant, because her medical needs can be met with services offered in the community.

On [redacted] 2022, Maximus correctly denied the Appellant's request for approval of long-term care Medicaid because based on the provided

information, the Appellant does not meet the medically necessary criteria for nursing facility level of care.

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DECISION

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

Shelley Starr
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.