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

[redacted] **2023**
**SIGNATURE CONFIRMATION**

**CASE #** [redacted]
**CLIENT ID #** [redacted]
**REQUEST # 205292**

## NOTICE OF DECISION

## PARTY

[redacted]

## PROCEDURAL BACKGROUND

On [redacted] 2022, Maximus Management Innovations LLC ("Maximus"), 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 facility level of care ("NFLOC") as not being medically necessary.

On [redacted] 2022, the Appellant requested an administrative hearing to contest Maximus' decision to deny his NFLOC.

On [redacted] 2023, the Office of Legal Counsel, Regulations, and Administrative Hearings (the "OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2022, to be conducted via telephone conference.

On [redacted] 2022, the Appellant requested the hearing be rescheduled.

On [redacted], 2023, the OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2023, to be conducted via telephone conference.

On [redacted] 2023, the Appellant's Power of Attorney requested the hearing be rescheduled as he would not be available due to out-of-town business.

On [redacted] 2023, the OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2023, to be held via telephone conference.

On [redacted] 2023, the Appellant requested the hearing be rescheduled as no administrative hearing summary had been received.

On [redacted] 2023, the OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2023, to beheld via telephone conference.

On [redacted] 2023, the administrative hearing was held via telephone conference and the following individuals participated:

[redacted] Appellant
[redacted] Appellant's Brother/Power of Attorney
[redacted] Facility Dementia Unit Manager
Janice Ricciuti, Community Nurse Coordinator, Community Options, DSS
Paul Cook, Maximus Representative
Joseph Alexander, Administrative Hearing Officer, DSS OLCRAH

## STATEMENT OF THE ISSUE

The issue to be decided is whether Maximus' decision to deny the NFLOC for the Appellant as not being medically necessary was correct.

## FINDINGS OF FACT

1. The Appellant is [redacted] years old ([redacted] and a recipient of the Husky D Medicaid program. (Exhibit 6: Level of Care Determination)

2. On [redacted] 2021, the Appellant was admitted to [redacted] (the "Facility") with the following admitting diagnoses; (1) acute metabolic encephalopathy, (2) shock, (3) hypertension, (4) slow heart rate, (5) prolonged QT on ECG, (6) ischemic heart disease, (7) COPD exacerbation, (8) sleep apnea, (9) pulmonary HTN, (10) AKI, (11) urinary tract infection due to enterococcus, (12) decreased platelet count, (13) monoclonal para proteinemia, (14) ETOH dependence, (15) opioid use, (16) DM II, (17) testicular hypogonadism, and (18) low NA levels. (Exhibit 6: Level of Care Determination, Hearing Record)

3. On [redacted] 2021, the Facility submitted a Nursing Facility Level of Care ("NFLOC") screening form to Maximus describing the Appellant's Activities of Daily Living ("ADL") support needs as requiring hands on assistance with bathing, dressing, toileting, and transfer. The Appellant's Instrumental Activities of Daily Living ("IADL") were described as requiring no assistance medications and no assistance with meal preparation. Based on this information the Appellant received a one hundred and twenty (120) day approval. This approval was scheduled to expire on [redacted] 2022. (Hearing Record)

4. On [redacted] 2022, the Appellant began receiving Occupational Therapy. The Occupational Therapy ended on [redacted] 2022. (Exhibit 15: Occupational Therapy Notes)

5. On [redacted] 2022, the Facility submitted a NFLOC screening form to Maximus describing the Appellant's ADL support needs as requiring supervision with bathing. The Appellant's IADL support needs were described as requiring no assistance with medications, and minimal assistance with meal preparation. Based on this information the Appellant received a sixty (60) day approval. This approval was scheduled to expire on [redacted] 2022. (Hearing Record)

6. On [redacted] 2022, the Appellant began receiving Physical Therapy. The Physical Therapy ended on [redacted] 2022. (Exhibit 14: Physical Therapy Notes)

7. On [redacted] 2022, the Facility submitted a NFLOC screening form to Maximus for review. The Appellant's ADL support needs were described as requiring hands on assistance with bathing. The Appellant's IADLs were described as requiring no assistance with medications and minimal assistance with meal preparation. Based on this information the Appellant received a ninety (90) day approval. This approval was scheduled to expire on [redacted] 2022. (Hearing Record)

8. On [redacted] 2022, the Facility submitted an NFLOC screening form to Maximus for review. The Appellant's ADL support needs were described as requiring no assistance. The IDL support needs were described as requiring no assistance with medications and minimal assistance with meal preparation. Based on this information the Appellant received a one hundred and eighty (180) day approval. This approval was scheduled to expire on [redacted] 2022.

9. On [redacted] 2022, the Facility submitted an NFLOC screening form to Maximus describing the Appellant's ADL support needs as requiring hands on assistance with bathing, and supervision with dressing. The IADL support needs were described as requiring no assistance with medications and continual supervision with meal preparation. Based on this information the Appellant required a medical review. (Hearing Record)

10. On [redacted] 2022, a Medical Doctor review was conducted using the following information related to the Appellant's medical and total needs; (1) Practitioner Certification, (2) Minimum Data Set, (3) Progress Notes, (4) Physician Orders, (5) Behavioral Health Note, (6) Occupational Therapy Notes, (7) Physical Therapy Note, (8) Imaging Results, and (9) Routine Medications. The review concluded nursing facility level of care was not medically necessary for the Appellant and was not clinically appropriate in terms of the level of services provided because he did not require the continuous nursing services delivered at the level of the nursing facility and his needs could be met in the community in a less restrictive setting with appropriate supports. (Exhibit 7: Practitioner Certification, Exhibit 12: Minimum Data Set, Exhibit 9: Progress Notes, Exhibit 8: Physician orders, Exhibit 10: Behavioral

Health Note, Exhibit 15: Occupational Therapy Note, Exhibit 14: Physical Therapy Note, Exhibit 13: Imaging Results, Exhibit 11: Routine Medication)

11. On [redacted] 2022, a NOA was sent to the Appellant informing him that he did not meet the nursing facility level of care criteria. (Exhibit 5: Notice of Action)

12. On [redacted] 2022, the OLCRAH received the Appellant's hearing request form. (Exhibit 2: Hearing Request)

13. The Appellant needs to remain in a facility as he requires assistance with bathing, dressing, and toileting, has complex diabetes which requires the administration of insulin on a sliding scale, has chronic severe pain and arthritis which necessitates Physical Therapy for a minimum of six (6) weeks, and has delayed memory recall issues. (Facility Testimony)

14. The issuance of this decision is timely under Connecticut General Statutes ("Conn. Gen. Stat.") §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, making this decision due by [redacted] 2023. However, due to the rescheduling of this hearing, an additional seventy-seven (77) days have been added making this decision due no later than [redacted] 2023, as [redacted] 2023, falls on a Sunday.

## CONCLUSIONS OF LAW

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

   Conn. Gen. Stat. § 17b-261b (a) 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.

   Conn. Gen. Stat. § 17b-262 (a) 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, and (2) to prohibit the admission by such facilities of persons with primary psychiatric diagnoses if such admission would jeopardize federal reimbursements.

   **The Department has the authority under state statute to administer the HUSKY-D Medicaid program and make regulations for the same.**

2. Regulations of Connecticut State Agencies ("Regs., Conn. State Agencies") § 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 before the department authorizes 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 a mental illness or mental retardation as identified by the preadmission MI/MR screen.

   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 authorized to receive payment for nursing home services.**

3. Title 42 of the Code of Federal Regulations ("C.F.R.") § 409.31 (b) provides for specific conditions for meeting the 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 inpatient hospital or inpatient CAH services, or (ii) Which arose while the beneficiary was receiving care in an 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 an 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 an 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**.

4. 42 C.F.R. § 483.102 provides for the screening or reviewing of all individuals with mental illness or intellectual disability who apply to or reside in Medicaid certified NFs regardless of the source of payment for the NF services, and regardless of the individual's or resident's known diagnoses.

   42 C.F.R. § 483.104 provides as a condition of approval of the State Plan, the State must operate a preadmission screening and annual resident review program that meets the requirements of §§ 483.100 through 438.138.

   42 C.F.R. § 483.112 provides for the preadmission screening of applicants for admission to NFs. (a) Determination of need for NF services. For each NF applicant with MI or IID, the State mental health or intellectual disability authority (as appropriate) must determine, in accordance with § 483.130, whether, because of the resident's physical and mental condition, the individual requires the level of services provided by a NF. (b) Determination of need for specialized services. If the individual with mental illness or intellectual disability is determined to require a NF level of care, the State mental health or intellectual disability authority (as appropriate) must also determine, in accordance with § 483.130, whether the individual requires specialized services for the mental illness or intellectual disability, as defined in § 483.120.

   **Maximus properly reviewed the NFLOC screening forms submitted for evaluation of the Appellant per Federal regulations.**

5. Conn. Gen. Stats. § 17b-295b provides for the definition of “medically necessary” and “medical necessity” as follows: (a) For purposed 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 maintain the individual’s achievable health and independent functioning as provided such services are: (1) Consistent with generally acceptable 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 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.

**Although Maximus correctly based its [redacted] 2023, denial of NFLOC on the documents submitted by the Facility, the hearing record shows that the Facility did not fully disclose to Maximus the extent of the Appellant's memory recall issues, his inability to administer his medications due to his complex medical needs, and his deteriorating physical abilities related to bathing, dressing, and walking due to chronic and severe pain and arthritis.**

## DISCUSSION

**During the hearing, both the Appellant's POA and the Facility representative voiced their concerns regarding the Appellant's memory recall issues, inability to administer his medications due to his complex medical needs and the deterioration of his physical abilities due to chronic and severe pain and arthritis (walking, bathing, dressing).**

**The undersigned Hearing Officer finds it would be in the best interest of the Appellant to remain in a Facility until his complex medical issues (diabetes, chronic severe pain, and arthritis), and persisting dementia can be addressed and brought under control.**

## DECISION

The Appellant's appeal is **REMANDED** to the Facility for further action.

## ORDER

The Facility shall submit to Maximus for review, all documentation supporting the testimony provided during the hearing that the Appellant needs to remain under the care of a supervised nursing facility setting due to his complex medical needs and memory recall issues.

The Facility shall provide the undersigned hearing officer with confirmation such documentation has been sent to Maximus for review by no later than [redacted] 2023.

Joseph Alexander

**Joseph Alexander**
**Administrative Hearing Officer**

CC: hearings.commops@ct.gov
AscendCTadmihearings@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, 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 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 fooled 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.