STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3730

[redacted] **2023**
Signature Confirmation

Case ID # [redacted]
Client ID # [redacted]
Request # 208401

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2022, Ascend Management Innovations LLC ("Maximus"), the Department of Social Services contractor that administers approval of nursing home care, sent [redacted] (the "Appellant") a notice of action ("NOA") denying nursing facility ("NF") level of care ("LOC") as not being medically necessary.

On [redacted] 2023, the Appellant requested an Administrative Hearing to contest Maximus's decision to deny NF LOC.

On [redacted] 2023, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the Administrative Hearing for [redacted] 2023.

On [redacted] 2023, in accordance with sections 17b-60, 17-61, and 4-176e to 4-184 inclusive, of the Connecticut General Statutes, OLCRAH held an Administrative Hearing telephonically.

The following individuals participated in the hearing by telephonic conferencing:

[redacted] Appellant
[redacted] (the "Facility") Social Worker
Ellen Troyan, RN, DSS Central Office – Community Options
Jean Denton, Maximus
Jessica Gulianello, Hearing Officer

The hearing record remained open at the Appellant's request to allow the Facility time to submit additional information. No additional information was received from the Facility and on [redacted] 2023, the hearing record closed accordingly.

STATEMENT OF THE ISSUE

The issue is whether Maximus correctly denied the Appellant's request for NF LOC approval.

FINDINGS OF FACT

1. The Appellant is [redacted] ([redacted]) years old (DOB: [redacted]) and a Medicaid recipient of long-term care support services. *(Exhibit 6: Level of Care Determination Form [redacted] 2022, Hearing Record)*

2. The Appellant's medical history includes but is not limited to: [redacted]. *(Exhibit 6: Level of Care Determination Form [redacted] 2022)*

3. The Appellant was residing in [redacted] with his [redacted] prior to institutionalization. *(Appellant's Testimony)*

4. In 2020, the Appellant was hospitalized following [redacted]; the Appellant does not recall the details of the incident. *(Appellant's Testimony)*

5. On [redacted] 2020, the Appellant was discharged from the hospital and admitted to the Facility with the admitting diagnoses of [redacted]. *(Exhibit 6: Level of Care Determination Form, [redacted] 2022, Face Sheet, Hearing Summary)*

6. On [redacted] 2022, the Facility submitted the Nursing Facility Level of Care ("NFLOC") screening form to Maximus requesting a retrospective review with a start date of [redacted] 2022. The NFLOC screen described the individual's current Activities of Daily Living ("ADLs") support needs as follows: The Appellant required supervision

with bathing, dressing, eating, toileting, mobility, transfer, and continence. For Instrumental Activities of Daily Living ("IADLs"), the Appellant required physical assistance with medications and continual supervision with meal preparation. However, the Minimum Data Set ("MDS") as provided by the Facility reflected that the individual was independent with all ADLs. Based on this information Maximus determined that a medical doctor review was required. *(Hearing Summary, Maximus Testimony)*

7. On [redacted] 2022, Dr. [redacted], MD reviewed all available information relating to the Appellant's medical and total needs. Dr. [redacted] concluded that the NFLOC was not medically necessary for the Appellant as he does not require the continuous nursing services delivered at the NF and the services provided are not considered effective for his condition. The Appellant's needs could be met in a less restrictive setting through a combination of medical, psychiatric, and social services delivered outside of the NF setting. *(Hearing Summary, Maximus Testimony)*

8. On [redacted] 2022, Maximus issued a NOA to the Appellant and the Facility indicating short-term NF placement is not medically necessary for the Appellant. *(Hearing Summary, Maximus Testimony)*

9. Maximus reviewed the information reported on the NFLOC screening form, and the *recalled* historical needs of the Appellant reflected on the LOC ADL Supervision Flow Sheets and determined it to be inconsistent with the supporting documentation and not aligned with the MDS. *(Maximus Testimony)*

10. The Appellant is independent with his ADLs. He does not require hands-on assistance with bathing, dressing, eating, toileting, continence, transferring, or mobility. *(Exhibit 15: MDS [redacted] 2022, Appellant's Testimony)*

11. The Appellant's current prescription medications include, but are not limited to: [redacted]. *(Exhibit 11: Physician Orders, [redacted] 2022)*

12. The Appellant does not require the assistance of medical adaptive equipment. *(Appellant's Testimony)*

13. The Appellant is not currently receiving speech, occupational, or physical therapy services. *(Hearing Record)*

14. Neither the Appellant nor the Facility submitted evidence 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)*

15. 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] 2023. This decision, therefore, was due no later than [redacted] 2023, did not close for the admission of evidence until [redacted] 2023, at the Appellant's request. Because this one [redacted] day in the close of the hearing record arose from the Appellant's request, this final decision was not due until [redacted] 2023, and is therefore timely. *(Hearing Record)*

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes 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.

2. Section 17b-262-707(a) of Regulations of Connecticut State Agencies 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*.

    Section 17b-262-707(b) of the Regulations of Connecticut State Agencies 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 NF services.

3. Section § 17b-259b(a) of the Connecticut General Statutes provides 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 determining medical necessity.

   Title 42 of the Code of Federal Regulations § 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 the Appellant does not have uncontrolled and/or unstable conditions requiring continuous skilled nursing services.

   Maximus correctly determined that NF services are not clinically appropriate in terms of level of service or considered effective for the Appellant's illness, injury, or disease. Maximus correctly determined that NF services are not medically necessary for the Appellant because she does not need substantial assistance with personal care on a daily basis.

   Ascend correctly determined that the Appellant does not meet the medically necessary criteria for a NF LOC.

DISCUSSION

The hearing record reflects that Maximus approved the Appellant for a short term NFLOC that expired on [redacted] 2020. The Facility subsequently submitted NFLOC screening forms to Maximus on the respective dates: [redacted] 2020, [redacted], 2020, [redacted], 2021, and [redacted] 2022. Maximus requested additional information from the Facility following the receipt of said referrals. The Facility did not provide the information requested and the referrals were determined to be incomplete and withdrawn.

On [redacted] 2022, the Facility again submitted a NFLOC screening form to Maximus. Based on the information received Maximus determined that a medical doctor review was required. Dr. [redacted] reviewed all available information relating to the Appellant's medical and total needs and concluded that short term NF placement was not medically necessary. On [redacted], 2022, Maximus issued a NOA to the Appellant and the Facility advising of the NFLOC denial. On [redacted] 2022, the OLCRAH had an administrative hearing for the Appellant to contest the NFLOC denial. On [redacted] 2022, the OLCRAH issued a decision affirming the NFLOC denial as issued by Maximus.

The issue of this hearing is whether Maximus correctly denied the Appellant's request for NF LOC approval based on the NFLOC screening referral submitted on [redacted] 2022. Denial of the NFLOC screening referral submitted to Maximus prior to [redacted] 2022, is beyond the scope of this hearing.

DECISION

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

Jessica Gulianello

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Jessica Gulianello
Hearing Officer

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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, law, and 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 requested 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 the 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 the 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 if 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 to 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 following §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.