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 # 209721

NOTICE OF DECISION
PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2022, Maximus 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 denying the nursing facility level of care ("NFLOC") for the Appellant as not being medically necessary.

On [redacted], 2023, the Appellant requested an administrative hearing to contest Maximus' decision to deny the Appellant NFLOC.

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.

The following individuals participated in the hearing:

[redacted], Appellant
[redacted] Director of Social Services, [redacted]
Jean Denton, LPN, Maximus
Erin Scafe, RN, Department of Social Services
Scott Zuckerman, Hearing Officer

STATEMENT OF THE ISSUE

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

FINDINGS OF FACT

1. The Appellant is 47 years old (DOB [redacted]) and a Husky A Medicaid recipient of long-term care support services. (Record)

2. On [redacted] 2022, the Appellant was admitted to [redacted] (the "Facility") with a diagnosis of unspecified convulsions. (Hearing Record)

3. On [redacted] 2022, the Facility submitted a NFLOC referral to Maximus. The NFLOC screening form described the Appellant's current Activities of Daily Living ("ADLs") support needs as follows: The Appellant required hands-on assistance with bathing, dressing, toileting, and mobility and supervision with transfers. For Instrumental Activities of Daily Living ("IADLs"), the Appellant required minimal assistance with meal preparation and physical assistance with medications. Based on this information the Appellant received a short-term approval for 150 days with an end date of [redacted] 2022. (Hearing Summary)

4. On [redacted] 2022, the Facility submitted a NFLOC referral to Maximus. The NFLOC screen described the Appellant's current ADL support needs as follows: The Appellant required supervision with bathing, dressing, toileting, transferring, and mobility. For IADLs, the Appellant required set-up assistance with medications and required assistance with meal preparation. Based on this information, the Appellant required a medical doctor review. The review determined that the Appellant's needs could be met in the community with appropriate supports. The Minimum data set ("MDS") describes the Appellant independent with ADLs. (Hearing Summary)

5. On [redacted], 2022, Bill Regan, MD, reviewed the information available relating to the Appellant's medical and total needs to determine if NFLOC is medically necessary for the Appellant. The review determined that the Appellant's needs could be met in the community with appropriate supports. Dr. Regan determined that the Appellant is independent with all ADLs. The Appellant is not receiving any rehabilitative services such as Physical Therapy ("PT"), Occupational Therapy ("OT"), Speech Therapy ("ST"), or Respiratory Therapy ("RT"). Dr. Regan determined the Appellant's needs could be met in a less restrictive setting and NFLOC is not medically necessary because she does not require the continuous nursing services delivered at the level of the nursing facility. (Hearing Summary; Exhibit 6: Level of Care screening form, [redacted] 2022, Exhibit 7: Practitioner Certification; Exhibit 8: Minimum Data Set, Exhibit 9: Physicians Order, Exhibit 10: Psychiatric Evaluation and Consultation)

6. On [redacted], 2022, Maximus sent the Appellant a notice of action denying NFLOC. The notice stated based on a comprehensive assessment of your and your medical condition, that nursing facility level of care is not medically necessary because: It is not considered effective for you and is not clinically appropriate in terms of level. The Appellant does not require the continuous nursing services delivered at the level of the facility. Her needs could be met in a less restrictive setting with a combination of medical, psychiatric, and social services delivered outside of the NF setting. She would need intermittent assistance through home health, visiting nurse of some other venue to monitor her condition. She is noted to be able to complete ADLs without assistance. (Exhibit 5: Notice of Action, [redacted], 2022)

7. The Appellant is independent with her ADLs including eating, toileting, continence, transferring, and mobility. The Appellant is not in receipt of physical therapy, occupational therapy, or speech therapy. The Appellant receives medication administration at the facility. (Appellant's testimony, Exhibit: 8)

8. The Appellant does not have a cognitive or behavioral impairment. (Hearing Summary, Appellant's testimony, and Exhibit 13: Minimum data set)

9. The Appellant is currently working with the Department's Money Follows the Person program. (Appellant's and Facility's testimony)

10. 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], 2023. Therefore, this decision is due not later than [redacted] 2023. (Hearing Record)

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.

2. Regulations of Connecticut State Agencies ("Regs., Conn. State Agencies") § 17b-262-707 (a) 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 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 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 had 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 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.

   42 C.F.R § 483.128 (a) provides the State's PASRR program must identify all individuals who are suspected of having MI or IID as defined in §483.102. This identification function is termed Level I. Level II is the function of evaluating and determining whether NF services and specialized services are needed. The State's performance of the Level I identification function must provide at least, in the case of first-time identifications, for the issuance of written notice to the individual or resident and his or her legal representative that the individual or resident is suspected of having MI or IID and is being referred to the State mental health or intellectual disability authority for Level II screening.

   42 C.F.R. § 483.132 (a) provides that for each applicant for admission to a NF and each NF resident who has MI or IID, the evaluator must assess whether: (1) The individual's total needs are such that his or her needs can be met in an appropriate community setting; (2) The individual's total needs are such that they can be met only on an inpatient basis, which may include the option of placement in a home and community-based services waiver program, but for which the inpatient care would be required; (3) If inpatient care is appropriate and desired, the NF is an appropriate institutional setting for meeting those needs in accordance with §483.126; or; (4) If the inpatient care is appropriate and desired but the NF is not the appropriate setting for meeting the individual's needs in accordance with §483.126, another setting such as

an ICF/IID (including small, community-based facilities), an IMD providing services to individuals aged 65 or older, or a psychiatric hospital is an appropriate institutional setting for meeting those needs.

42 C.F.R. § 483.132 (b) provides for *Determining appropriate placement.* In determining appropriate placement, the evaluator must prioritize the physical and mental needs of the individual being evaluated, taking into account the severity of each condition.

42 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 a Level I evaluation of the Appellant per Federal regulations.

Maximus' review of the Appellant's medical condition shows the Appellant is independent with her ADLs and does not require specialized services for either mental illness or intellectual disability.

5. Conn. Gen. Stat. § 17b-259b provides (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.

   Conn. Gen. Stat. § 17b-259b (b) provides 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.

Conn. Gen. Stat. § 17b-259b (c) provides 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.

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.

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

The Appellant is able to complete her ADLs independently. She does not need extensive day-to-day assistance with personal care including eating, toileting, bathing, eating, transferring, mobility, and dressing.

Maximus was correct in its determination that the Appellant did not meet the medically necessary criteria for nursing facility level of care.

DECISION

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

Scott Zuckerman
Scott Zuckerman
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.