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

[redacted], 2023
Signature Confirmation

[redacted]
[redacted]
Request #: 213824

NOTICE OF DECISION

PARTY

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

PROCEDURAL BACKGROUND

On [redacted], 2023, Maximus Management Innovations LLC., ("Maximus"), the Department of Social Service's contractor that administers approval of nursing home care services, sent [redacted] (the "Appellant") a Notice of Action ("NOA") denying the Appellant nursing facility level of care ("NFLOC") because he does not meet the medical necessity criteria.

On [redacted] 2023, the Appellant requested an administrative hearing to contest Maximus' denial of his NFLOC request.

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, 17b-61 and 4-176e to 4-184 inclusive, of the Connecticut General Statutes, OLCRAH held a telephonic administrative hearing.

The following individuals participated in the hearing:

[redacted]
[redacted], Director of Social Services, [redacted]
Jean Denton, LPN, Clinical Supervisor, Maximus Representative

Allison Weingart, Community Nurse Coordinator, Community Options
Amy MacDonough, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue is whether Maximus correctly denied the Appellant's request for NFLOC because he does not meet the medical necessity criteria.

FINDINGS OF FACT

1. The Appellant is [redacted] years old [Date of Birth: [redacted]] and a recipient of Husky D Medicaid. *(Appellant's Testimony, Exhibit 6: Level of Care Determination Form)*

2. On [redacted] 2022, the Appellant entered [redacted] with the diagnosis of repeated fall. *(Hearing Record; Maximus' Testimony; Exhibit 6)*

3. On [redacted], 2022, the Facility submitted the NFLOC screening form to Maximus for review. The NFLOC screening form described the Appellant's current Activities of Daily Living ("ADL") support needs as follows: The Appellant required hands on assistance with bathing, dressing, toileting, mobility, transfer and continence and supervision with eating. For Instrumental Activities of Daily Living ("IADL"), the Appellant required supervision with meal preparation, and verbal assistance with medications. Maximus granted a 90-day short term approval, which expired on [redacted] 2022. *(Hearing Record; Maximus' Testimony)*

4. On [redacted] 2022, the Facility submitted the NFLOC screening form to Maximus for review. The NFLOC screening form described the Appellant's current ADL support needs as follows: The Appellant required hands on assistance with bathing, transfer, and continence, and supervision with dressing, eating, toileting, and mobility. For IADL's, the Appellant required verbal and physical assistance with medications, and minimal assistance with meal preparation. Maximus determined the Appellant required a medical doctor review. *(Hearing Record; Maximus' Testimony)*

5. Maximus' medical doctor reviewed the NFLOC, Practitioner Certificate, Order Summary Report, Progress Notes, Point of Care History, and Minimum Data Set, and determined that the nursing facility level of care is not medically necessary for the Appellant as he does not require the continuous nursing services delivered at the level of the nursing facility and his needs could be met in a less restrictive setting. During this review, Maximus found the ADL support needs as follows: independent in bathing, dressing, toileting, continence, transferring, and mobility, and required supervision with eating. The Appellant required verbal and physical assistance with medication support. *(Hearing Record; Maximus' Testimony)*

6. On [redacted] 2022, Bill Regan MD, reviewed all available information relating to the Appellant's medical and total needs and determined that nursing facility level of care is not medically necessary for the individual because it is not clinically appropriate in terms of the level of services provided and is not considered effective for his condition, and his needs could be met through a combination of medical and psychiatric follow up, as well as social services provided outside of the nursing facility setting. *(Hearing Record; Maximus' Testimony)*

7. On [redacted], 2023, Maximus sent the Appellant a NOA denying NFLOC as it is not medically necessary. *(Hearing Record; Maximus' Testimony)*

8. The Appellant experienced a set back and returned to Physical Therapy ("PT") 5 days a week, which ended in [redacted] 2023. *(Facility's Testimony)*

9. On [redacted] 2022, the Facility submitted the NFLOC screening form to Maximus for review. The NFLOC screen described the ADL support needs as follows: the Appellant required hands on assistance with bathing, and continence, and supervision with dressing, toileting, transfer, and mobility. For IADL, the Appellant required verbal and physical assistance with medications and minimal assistance with meal preparation. Maximus granted a 180-day short term approval, which expired on [redacted] 2023. *(Hearing Record; Maximus' Testimony)*

10. On [redacted] 2023, the Facility submitted the NFLOC screening form to Maximus for review. The NFLOC screen described the ADL support needs as follows: the Appellant required supervision with bathing, dressing, eating, and transfer. For IADL, the Appellant required set up assistance with medications and minimal assistance with meal preparation. Maximus requested a medical doctor review. *(Hearing Record; Maximus' Testimony)*

11. On [redacted] 2023, Bill Regan MD, reviewed all available information relating to the Appellant's medical and total needs and concluded that nursing level of care is not medically necessary for him because it is not clinically appropriate in terms of the level of services provided and is not considered effective for his condition. Dr. Regan determined the Appellant currently does not require the continuous and intensive nursing care as provided at the nursing facility level, and his needs could be met through a combination of medical and psychiatric follow up, as well as social services provided outside of the nursing facility setting. *(Hearing Record; Maximus' Testimony)*

12. On [redacted], 2023, Maximus issued a NOA to the Appellant denying the Appellant's NFLOC as not medically necessary. The NOA explained that the Appellant does not require the continuous nursing services delivered at the level of the NF. His needs could be met through the combination of medical, psychiatric, and social services delivered outside of the NF setting. He would need intermittent assistance through home health, visiting nurse or some other venue to monitor his condition. *(Hearing Record; Maximus' Testimony; Exhibit 5: Notice of Action)*

13. The Appellant takes one medication daily, vitamin B-12. This medication is taken orally. *(Appellant's Testimony)*

14. The Facility reported that the Appellant has been accepted into a residential care home and has a scheduled discharge date of [redacted] 2023. The Appellant agrees with the facilities plan for discharge. *(Facility's Testimony; Appellant's Testimony)*

15. The issuance of this decision is timely under Section 17b-61(a) of the Connecticut General Statutes, which provides that the agency shall issue a decision within 90 days of receipt of a request for an Administrative Hearing. The Appellant requested an administrative hearing on [redacted], 2023; therefore, this decision is due no later than [redacted], 2023.

CONCLUSIONS OF LAW

1. Section 17b-2(6) of the Connecticut General Statutes provides the Department of Social Services is designated as the State agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

   Section 17b-262(a) 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, and (2) to prohibit the admission by such facilities of persons with primary psychiatric diagnoses if such diagnoses 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. Section 17b-262-707(a) of the Regulations of Connecticut State Agencies provides for need for service and authorization process and states 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.

Section 17b-262-707(b) of Regulations of Connecticut State Agencies provides that the department shall pay a provided 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. Section 19-13-D8t(d)(1)(A) of Regulations of Connecticut State Agencies provides for chronic and convalescent nursing homes and rest homes with nursing supervisor, patient admission and states 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 and/or chronic conditions requiring continuous skilled nursing services and/or nursing supervision or has chronic conditions requiring substantial assistance with person care, on a daily basis;
   (ii) That a patient admitted to a rest home with nursing supervision has controlled and/or stable chronic conditions which require minimal skilled nursing services, nursing supervision, or assistance with personal care on a daily basis.

The Appellant has previously met the NFLOC criteria prior to the issuance of the [redacted], 2023 notice of action denying such approval.

4. Title 42 of the Code of Federal Regulations ("C.F.R.") Section 409.31(b) provides for specific conditions for meeting level of care requirements and states (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 a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital or inpatient CAH services; or (iii) or 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.

5. 42 C.F.R §483.132 provides for evaluating the need for NF services and NF level of care (PASARR/NF), and states 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 a n 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 and states 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 for data and states at a minimum, the data relied on to make a determination 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).

Based on the information provided to Maximus, and the medical doctors review, Maximus correctly determined the Appellant did not have uncontrolled and/or chronic conditions requiring continuous skilled nursing services.

6. Section 17b-259b of the Connecticut General Statutes provides for “medically necessary” and “medical necessity” defined. Notice of denial of services. Regulations. 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.

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's medical conditions do not require NFLOC and can be met in a less restrictive setting.

Maximus correctly denied the Appellant's LOC request for nursing home services as not medically necessary.

DECISION

The Appellant's appeal is **DENIED**

Amy MacDonough
Fair Hearing Officer

CC: 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.