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

[redacted] 2023
Signature Confirmation

Client ID [redacted]
Case ID [redacted]
Request # 214518

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2023, Maximus, the Department of Social Services' (the "Department") contractor that administers approval of nursing home care, sent [redacted] (the "Appellant") a notice denying [redacted] (the "facility") [redacted] 2023 prior authorization request for nursing facility level of care ("NFLOC") on behalf of the Appellant as not medically necessary.

On [redacted] 2023, the Appellant requested an administrative hearing to contest Maximus's decision to deny 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, the Appellant requested a continuance which OLCRAH granted.

On [redacted] 2023, the 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 4-189 inclusive of the Connecticut General Statutes, OLCRAH held an administrative hearing.

The following individuals were present for the hearing:

[redacted] Appellant
[redacted], Social Worker, [redacted]
[redacted], Rehabilitation Director, [redacted]
[redacted], Administrator, [redacted]
Paul Cook, RN, Maximus Representative, participated by telephone
Benille St. Jean, RN, Department of Social Services Representative
Lisa Nyren, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Maximus's [redacted] 2023 decision to deny the facility's [redacted] 2023 request for a NFLOC determination on behalf of the Appellant as not medically necessary was correct.

FINDINGS OF FACT

1. On [redacted] 2022, the facility, a skilled nursing facility, admitted the Appellant with an admitting diagnosis of sepsis, essential hypertension, arthropathy, fusion of spine cervical region, urinary tract infection, and polyneuropathy. (Exhibit 3: Hearing Summary, and Exhibit 6: Level of Care Determination Form, Exhibit 8: Order Summary, and Appellant Testimony)

2. The Appellant is [redacted] years old born on [redacted]. (Exhibit 6: LOC Determination Form)

3. Sepsis is a generalized bacterial or viral infection that has spread throughout the body, including organs and/or blood. The Appellant received treatment for sepsis and has recovered. (Maximus Representative Testimony and Appellant's Testimony)

4. Essential hypertension is high blood pressure. (Maximus Representative Testimony)

5. Arthropathy refers to arthritis. In 1997, the Appellant received a diagnosis of arthritis. (Maximus Representative Testimony and Appellant Testimony)

6. Fusion of spine cervical region references the Appellant's surgery which fused vertebrae in his neck. (Maximum Representative Testimony and Appellant Testimony)

7. The Appellant's urinary tract infection is resolved. (Appellant's Testimony)

8. Polyneuropathy refers to the Appellant's degeneration of disc and spine causing compression on the spine, general weakness, generalized neuropathy, and a decrease in sensation. (Hearing Record)

9. Maximus is the Department's contractor that determines if a patient meets the NFLOC criteria to authorize payment under Medicaid for their stay at a facility. (Maximus Representative's Testimony)

10. On [redacted] 2023, the facility submitted the Connecticut Level of Care Form ("LOC determination form") to Maximus requesting NFLOC approval on behalf of the Appellant for a continued stay of 61-90 days at the facility beginning [redacted] 2023. The facility requested a retrospective review. On the LOC determination form, the facility indicates the Appellant has uncontrolled, unstable, and/or chronic conditions requiring continuous skilled nursing services and/or nursing supervision daily or has chronic conditions requiring substantial assistance with personal care daily. Under related skilled nursing service(s) skilled nursing daily is listed and under medical diagnosis meds is listed. No therapies ordered. The facility lists medication supports setup due to being in a skilled nursing facility. The facility lists the Appellant independent or supervision less than daily for bathing, dressing, eating, toileting, mobility, transfer, and continence. The facility lists the Appellant requires no assistance for meal preparation and fully oriented for self, place, time, and situation. The facility notes no issues or problems with communication, memory, judgment, vision, or behaviors. (Exhibit 6: LOC Determination Form)

11. The facility submitted supporting documentation with the LOC determination form. The supporting documents included Activities of Daily Living ("ADL") schedule, Order Summary, [redacted] 2022 Minimum Data Set ("MDS"), and History and Physical Exam. (Hearing Record)

12. The ADL schedule lists the [redacted] 2023 ADL's completed by the Appellant. The ADL schedule support the Appellant is independent with personal and oral hygiene, toileting, bathing, dressing, mobility, and locomotion. (Exhibit 7: ADLS Schedule, Social Worker Testimony, and Appellant Testimony)

13. The Appellant takes no prescription medications. The Appellant takes over the counter vitamin B12 and D3 tablets and suppository for constipation as needed. (Exhibit 8: Order Summary and Appellant Testimony)

14. On [redacted] 2023, the facility completed the most recent MDS which describes the functional status of the Appellant. However, the facility did

not submit the most recent MDS, rather submitted the [redacted] 2022 MDS for review. In [redacted] the MDS confirmed the Appellant independent in the following activities of daily living ("ADL's"): bed mobility, locomotion on and off the unit, and eating. The Appellant required one person assist for transfers, walking in room and corridors, dressing, toilet use, and personal hygiene. The facility notes the Appellant not steady during transitions and walking, but able to stabilize without staff assistance. The Brief Interview for Mental Status ("BIMS") indicates no cognitive impairments or mood disorders. (Exhibit 9: MDS and Social Worker Testimony)

15. Upon review of the LOC form, ADL schedule, Order Summary, MDS, and History and Physical Exam, Maximus determined the Appellant did not meet NFLOC criteria as the evidence submitted from the facility does not support the need for NFLOC. Maximus determined NFLOC is not considered effective and not clinically appropriate for the Appellant at this level. Maximus determined NFLOC is not medically necessary for the Appellant because he does not require the continuous nursing services delivered at the level of the nursing facility. Maximus determined the Appellant's needs could be met in a less restrictive setting. Maximus determined the Appellant independent with ADL's, does not require skilled therapy, has no cognitive needs and does not have a diagnosis of an uncontrolled or unstable medical condition. (Hearing Record)

16. On [redacted] 2023, Maximus issued a notice of action to the Appellant. The notice stated Maximus determined that "nursing facility level of care is not medically necessary for you at this time. ... We decided, based on a comprehensive assessment of you 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." (Exhibit 5: Notice of Action)

17. The Appellant uses a wheelchair to ambulate but can move about his room with the use of a walker, specifically to use the bathroom. (Appellant's Testimony)

18. The Appellant does not have an uncontrolled, unstable or chronic condition which requires he remain at the facility. The Appellant is independent in all his ADL's. The Appellant seeks to remain at the facility until appropriate housing which can accommodate his near full time status in a wheelchair is located. (Appellant's Testimony and Social Worker Testimony)

19. 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, and therefore timely.

CONCLUSIONS OF LAW

1. Section 17b-2(6) of the Connecticut General Statute ("Conn. Gen. Stat.") provides that 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.

2. Section 17b-262-707(a) of the Regulations of Connecticut State Agencies ("Regs., Conn. State Agencies") provides as follows:

   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.

3. "The Department shall pay a provider only when the department has authorized payment for the client's admission to that nursing facility." Regs., Conn. State Agencies § 17b-262-707(b)

4. State regulation provides as follows:

   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 person care, on a daily basis.

Regs., Conn. State Agencies § 19-13-D8t(d)(1)(A)(i)

5. State statute provides as follows:

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(a)

6. State Statute provides as follows:

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(b)

7. State Statute provides as follows:

The Department of Social Services shall amend or repeal any definitions in the regulations of Connecticut state agencies that are inconsistent with the definition of medical necessity provided in subsection (a) of this section, including the definitions of medical appropriateness and medically appropriate, that are used in administering the department's medical assistance program. The commissioner shall implement policies and procedures to carry out the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal not later than twenty days after implementation. Such policies and procedures shall be valid until the time the final regulations are adopted.

Conn. Gen. Stat. § 17b-259b(d)

8. “The department shall review the medical appropriateness and medical necessity of medical goods and services provided to Medical Assistance Program clients both before and after making payment for such good and services.” Regs., Conn. State Agencies § 17b-262-527

9. State regulation provides as follows:

   Prior authorization, to determine medical appropriateness and medical necessity, shall be required as a condition of payment for certain Medical Assistance Program goods or services as set forth in the regulations of the department governing specific provider types and specialties. The department shall not make payment for such goods and services when such authorization is not obtained by the provider of the goods or services.

   Regs., Conn. State Agencies § 17b-262-528(a)

10. “Prior authorization shall be granted by the department to a provider to furnish specified goods or services within a defined time period as set forth in the regulations of the department governing specific provider types and specialties.” Regs., Conn. State Agencies § 17b-262-528(b)

11. State regulation provides as follows:

    In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

    Regs., Conn. State Agencies § 17b-262-528(d)

12. State statute provides as follows:

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

13. **Maximus correctly determined the Appellant does not meet NFLOC criteria as established in state statute and state regulation because the Appellant does not require continuous skilled nursing services for an uncontrolled or unstable chronic condition or supervision for a chronic condition that requires substantial assistance with personal care daily. Additionally, the Appellant is independent in bathing, dressing eating, toileting, continence, transfer, and ambulation with the use of a wheelchair and no longer requires the services provided at the level of a skilled nursing facility. Medical documentation provided by the facility does not support the need for continuous skilled nursing services. It is noted the hearing record is void of a physician's certification certifying the need for NFLOC. The Appellant testified he seeks to remain in the facility only until placement in a residential care home is located and secured.**

> **Maximus correctly denied the facility's request for NFLOC review on behalf of the Appellant as not medically necessary, as defined by section 17b-259b(a) of the Connecticut General Statute.**

DECISION

The Appellant's appeal is denied.

Lisa A. Nyren
Lisa A. Nyren
Fair Hearing Officer

CC: DSS Community Options Division: hearings.commops@ct.gov
Maximus: AscendCTadminhearings@maximus.com
[redacted], Social Worker, [redacted]

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.