**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 # 223610

## 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, 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 at the facility.

The following individuals were present for the hearing:

[redacted] Appellant
[redacted] LNHA, Administrator, [redacted]
Robert Mostellar, Lead Clinical Coordinator, Maximus Representative, Participated by teleconference.

Charles Bryon, RN, Department of Social Services Representative, Participated by teleconference.
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 that included cellulitis unspecified and pressure ulcer of sacral region stage 2. Cellulitis is a bacterial skin infection. Pressure ulcer stage 2 occurs when the skin is broken and leaves an open wound over time usually from remaining in one position over time. This requires extensive wound care. (Exhibit 3: Hearing Summary, and Exhibit 6: Level of Care Determination Form)

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

3. 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 Testimony)

4. 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 Long-Term stay at the facility beginning [redacted] 2023. This included a retroactive 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 listing the Appellant's medical diagnosis as chronic unstable hyperlipidemia and chronic unstable essential primary hypertension. The facility lists skilled nursing services as: safety, medication, and lab monitoring and medication intake and output ("I&O") monitoring. No therapies ordered. The facility lists the Appellant independent or supervision less than daily for dressing, eating, transfer, and continence. The facility lists bathing and toileting supports as hands on with mobility supervision daily. The Appellant does not require meal preparation assistance. Appellant fully orientated with self, place, time, and situation. No issues with memory,

judgment, communication or behaviors noted. (Exhibit 6: LOC Determination Form)

5. The facility submitted supporting documentation with the LOC determination form. The supporting documentation included the Practitioner Certification signed on [redacted] 2023 attesting the Appellant meets NFLOC, Progress Notes, Resident Profile, [redacted] Activities of Daily Living ("ADL") Flow Sheets, Minimum Data Set ("MDS"), and Physician's Orders. (Hearing Record)

6. The Progress Notes dated [redacted] 2023 provide that the Appellant's blood pressure remains stable with medication. Test results show potassium level low (hypokalemia). Potassium prescribed and request made for new potassium check for following day. (Exhibit 8: Progress Notes)

7. The ADL Flow Sheets for period [redacted] 2023 through [redacted] 2023 lists the Appellant independent for transfers with the use of bed rails, independent with eating with minimal set up help given on a few occasions, independent with toileting with minimal set up help given on a few occasions and weekly shower. Bladder function continent. General Administration History for the same period include CBC quarterly, potassium level check on [redacted] 2023, and weekly vital checks and medication administration logs. (Exhibit 10: ADL Flow Sheets)

8. On [redacted] 2023, the facility completed the MDS which describes the functional status and cognitive patterns of the Appellant. The MDS notes the Appellant independent in the following ADL's: bed mobility, transfer, walk in room and corridor, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene but required set up help with bed mobility, transfers, walk in room, locomotion on unit, dressing, eating, toilet use, and personal hygiene. The Brief Interview for Mental Status ("BIMS") indicates no cognitive impairments noted as all questions were answered correctly with no cueing required. (Exhibit 11: MDS)

9. The Physicians Orders as of [redacted] 2023 include the following: medication list and administration, complete blood count (cbc) quarterly, basic metabolic panel (bmp) every four months, weekly vital signs, monitor for pain, dermatology follow-up, weekly skin checks, physical therapy evaluation as indicated, occupational therapy evaluation as indicated and psychological evaluation for depressed mood. The Physician Orders note independent with toileting with no use of assistive devices, use of rolling walker in room, and weekly showers. (Exhibit 12: Physician's Orders)

10. Approval for NFLOC is given when a resident has the presence of uncontrolled and/or unstable medical condition or a chronic medical

condition that requires continuous skilled nursing services. This includes the following: chronic condition with hands on support with three of more ADL's, dementia diagnosis which has resulted in cognitive deterioration that a structured, professional staffed environment is needed daily, chronic condition with supervision of more than three ADL's and one need factor, or chronic condition and hands on support with more than two ADL's daily and one need factor. Need factors include: physical therapy, occupational therapy, speech therapy, and rehabilitative services, cognitive need, behavioral need and/or medical supports. (Exhibit 3: Hearing Summary and Maximus Representative Testimony)

11. Upon review of the LOC determination form, Practitioner Certification, Progress Notes, Resident Profile, ADL Flow Sheets, MDS, and Physician's Orders, 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 as evidenced by the Physician's Orders, and has no cognitive needs. (Hearing Record)

12. 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)

13. The Appellant's current diagnosis includes high blood pressure, low potassium level, and pressure ulcer(s). The Appellant's medical condition is stable and controlled. The Appellant is independent in all ADL's: bathing, dressing, toileting, mobility with the use of a cane, transferring, and eating. The Appellant chooses to eat in his room rather than the dining room. The Appellant continues to experience pain when walking after he was hit by a car which resulted in serious injuries including two broken ankles. (Appellant Testimony)

14. The Appellant's admitting diagnosis: cellulitis and pressure ulcer, sacral region, has resolved. However he continues to be treated for pressure ulcers on his legs with medication and ointments. (Hearing Record)

15. It is the facility's practice to administer all medication to their residents whether or not the resident is capable to administer their own medication. (Administrator Testimony)

16. The Appellant seeks a continued stay at the facility to secure appropriate and safe housing before discharge. The Appellant has not left the facility since his admission except to attend medical appointments outside of the facility. The Appellant is able to walk for ten minutes before he must rest. (Appellant's Testimony)

17. 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.

## 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. Medical documentation provided by the facility does not support the need for continuous skilled nursing services. Although the facility provides the Appellant with medication management, it is provided to all residents at the facility. The Appellant is independent in bathing, dressing eating, toileting, continence, transfer, and ambulation as evidenced by the medical documentation submitted by the facility and the Appellant's testimony.**

**Maximus was correct in its determination that the Appellant does not meet the medical criteria for NFLOC.**

**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

## 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.