

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

[REDACTED] 2024
Signature Confirmation

Case # [REDACTED]
Client ID # [REDACTED]
Request # [REDACTED]

NOTICE OF DECISION

PARTY

[REDACTED]
[REDACTED]
[REDACTED]

PROCEDURAL BACKGROUND

On [REDACTED] 2023, Maximus Manager Innovations LLC (“Maximus”), the Department of Social Service’s (the “Department”) contractor that administers approval of nursing home care, sent [REDACTED] (the “Appellant”) a Notice of Action (“NOA”) denying nursing facility level of care (“NFLOC”) indicating that he does not meet the NFLOC criteria.

On [REDACTED] 2023, the Appellant requested an administrative hearing to contest Maximus’ decision to deny NFLOC criteria.

On [REDACTED] [REDACTED] 2023, the Office of Legal Counsel, Regulations, and Administrative Hearings (“OLCRAH”) issued a notice scheduling the administrative hearing for [REDACTED] 2024.

On [REDACTED] 2024, 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 at the hearing:

[REDACTED] Appellant
[REDACTED] Appellant’s Support Person
[REDACTED] Social Worker [REDACTED]
[REDACTED] Maximus Representative via telephone
Mary Perrotti, Department’s Community Nurse Coordinator
Alisha Laird, Fair Hearing Office

1. Section 17b-2 of the Connecticut General Statutes ("Conn. Gen. Stat") authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.
2. Conn. Gen. Stat. § 17b-261b(a) provides (a) 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.
3. 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 to administer Medicaid and make regulations regarding nursing home admissions.

4. Regulations of Connecticut State Agencies ("Regs., Conn. State Agencies") § 17b-262-707(a) provides 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
5. Regs., Conn. State Agencies. § 17b-262-707(b) 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 [REDACTED] and the facility was correctly authorized to receive payments for nursing facility services.

6. Regs., Conn. State Agencies § 19-13-D8t(d)(1)(A) provides 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 personal 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.
7. Title 42 of the Code of Federal Regulations (“C.F.R.”) § 409.31(a) provides skilled nursing and skilled rehabilitation services means services that: (1) Are ordered by a physician; (2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and (3) Are furnished directly by, or under the supervision of, such personnel.
8. 42 C.F.R. § 409.31(b)(1) provides 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) For 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. (3) The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis.

The Appellant previously met NFLOC criteria before the issuance of the notice of action dated [REDACTED] [REDACTED] 2023, denying such approval.

9. 42 C.F.R. 483.132(b) provides 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.
10. 42 C.F.R. 483.132(c) provides 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).

Maximus properly completed an evaluation and assessment of the Appellant per Federal Regulations.

Maximus' review of the Appellant's medical condition shows the Appellant requires hands-on assistance with [REDACTED], total assistance with [REDACTED], and physical assistance with [REDACTED]. The Appellant does not need continuous and intensive nursing care as provided at the nursing facility level.

11. Conn. Gen. Stat. § 17b-259b(a) 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.
12. Conn. Gen. Stat. § 17b-259b(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.
13. 42 C.F.R. § 440.230(d) provides for the Sufficiency of amount, duration, and scope. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

Maximus correctly determined that the Appellant does not currently have uncontrolled and/or unstable medical conditions requiring continuous skilled nursing services daily.

Maximus correctly determined that it is not clinically appropriate for the Appellant to reside in a nursing facility.

Maximus correctly determined that nursing facility services are not medically necessary for the Appellant, because his medical needs can be met with services offered in the community with appropriate support.

On [REDACTED] 2023, Maximus correctly denied the Appellant's request for approval of long-term care Medicaid because based on the provided information, the Appellant does not meet the medically necessary criteria for nursing facility level of care.

DECISION

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

Alisha Laird

Alisha Laird
Fair Hearing Officer

CC: [REDACTED] Social Worker [REDACTED]
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.