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

Client ID [redacted]
Case ID [redacted]
Request # 230198

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] 2024, 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 for the hearing:

[redacted], Appellant
[redacted], Social Worker, [redacted]
Jean Denton, LPN, Maximus Representative
Ellen Troyan, RN, Department of Social Services Representative
Lisa Nyren, Fair Hearing Officer

The hearing record remained open for the submission of additional medical documentation from the facility and an appeal review of NFLOC completed by Maximus. On [redacted] 2024, the hearing record closed.

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] 2023, the facility, a skilled nursing facility, admitted the Appellant after a brief stay in the hospital. The Appellant's admitting diagnosis include osteomyelitis, back pain, and hypertension. Osteomyelitis is an infection in the bone. (Social Worker Testimony and Maximus Representative Testimony)

2. The Appellant's diagnosis includes major depressive disorder ("MDD"), anxiety disorder, and post-traumatic stress disorder ("PTSD"). (Appellant Testimony and Exhibit 6: PASRR)

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's Testimony)

4. On [redacted] 2023, the hospital submitted the Preadmission Screening and Resident Review (PASRR) on behalf of the Appellant to Maximus requesting approval for his stay at the facility. Maximus approved a 30-day exempted hospital discharge to cover his stay at the facility. Approval expired on [redacted] 2023. (Hearing Summary)

5. 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 at the facility. (Exhibit 3: Hearing Summary)

6. On [redacted] 2023, the facility submitted a PASSR screening form to Maximus due to his diagnosis which includes MDD, anxiety disorder mixed with depression and PTSD. The PASSR screening form is used to determine if the individual has a serious mental illness and whether NFLOC is appropriate. (Exhibit 3: Hearing Summary and Maximus Representative Testimony)

7. On [redacted] 2023, Maximus reviewed the PASSR screening form and determined the Appellant's medical needs could be met in a community setting because he does not have a medical necessity for nursing facility placement and had been discharged from the facility. NFLOC is not considered effective for you and is not clinically appropriate in terms of amount of care. Maximus noted the Appellant independent with Activities of Daily Living ("ADLs") which include transfer, bathing, personal hygiene, dressing, and toileting. (Exhibit 6: PASSR, Exhibit 10: PASSR DBR Form, Maximus Representative Testimony)

8. The Appellant is [redacted] years old born on [redacted]. (Hearing Record)

9. 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 amount of care." (Exhibit 5: Notice of Action)

10. The Appellant participated in physical therapy and occupational therapy between [redacted] 2023 and [redacted] 2023 five times per week for four weeks. Currently the Appellant continues to do stretching exercises regularly for lower back pain. (Social Worker Testimony and Appellant's Testimony)

11. The Appellant requires hands on care for hygiene, bathing and dressing. The Appellant is incapable of washing up daily without the assistance of facility staff. The Appellant showers weekly with the hands on assistance of facility staff. The Appellant is incapable of dressing himself without the assistance of facility staff. The Appellant requires a walker for mobility and transfers. Although he is able to feed himself, the Appellant cannot prepare his meals without assistance. The Appellant requires assistance with his medication from facility staff because he is forgetful. The Appellant's hands shake as a result of medication. (Appellant Testimony)

12. 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. (Facility Representative Testimony)

13. The hearing record remains open for the submission of a NFLOC determination to be made by Maximus. Maximus' [redacted] 2024 was based on inaccurate information, specifically that the Appellant was discharged from the facility. The Appellant remains a resident of the facility. The hearing record remains open through [redacted] 2024 so

that the facility may resubmit, and Maximus can make a determination on NFLOC. (Hearing Record)

14. On [redacted] 2024, the facility completed a CTLOC form requesting prior authorization for NFLOC. The facility requested the stay as long-term. The facility lists the Appellant's medical diagnosis as Type 2 diabetes, MDD and PTSD and related skilled nursing services as insulin dependency, monitor psych medications, mood, and behaviors due to traumatizing past events. The facility notes the Appellant requires total assistance with bathing, dressing, toileting, and continence and supervision with eating, and hands on support with mobility and transfers. The facility writes, "Resident requires assistance for all of his ADL tasks as he is weak, and his functioning has declined substantially." (Exhibit 11: CTLOC Form)

15. On [redacted] 2024, Maximus conducted an onsite evaluation which included face to face staff interviews, direct observation, individual interview, and a review of medical records. Medical records included physical therapy ("PT") discharge summary, Minimum Data Set ("MDS"), Physician's Order, Complete Care Details, Practitioner Certificate, December Progress Notes, PT Evaluation and Plan of Treatment, and Occupational Evaluation and Plan of Treatment. Maximus concluded the Appellant's Type 2 diabetes and blood pressure is under control and labs and vitals are stable. The Appellant completed rehabilitative therapies and remains independent with ADLs. The Appellant walks to the courtyard independently for smoke breaks and deliveries and is able to independently complete ADLs and IADLs except for cooking and able to manage medications independently except for insulin because he requires reminding from staff. Maximus determined the Appellant does not meet medical necessity and denied the facility's request for NFLOC. (Exhibit 11: CTLOC Form)

16. Between [redacted] 2023 and [redacted] 2023, the Appellant received physical therapy. Physical therapy discharged the Appellant on [redacted] 2023 because the Appellant met both short term and long term goals that include perform functional transfers with correct hand and foot placement, ambulate on level surfaces with the use of a rollator and/or case, and navigate stairs. (Exhibit 13: Physical Therapy Discharge Report)

17. The MDS completed on [redacted] 2023 indicates the Appellant required extensive assistance toileting, but independent with bed mobility, transfers, eating, indoor mobility, stairs, functional cognition. At time of admission the Appellant required supervision with toileting, shower, dressing, and transfers. (Exhibit 14: MDS)

18. The Complete Care Details between [redacted] 2024 through [redacted] 2024 report the Appellant independent with no set up or physical help from staff in bed mobility, transfers, walking in room and corridor, locomotion in unit and off unit, dressing, toileting, personal hygiene, and bathing. Set-up help was provided with eating. (Exhibit 16: Complete Care Details)

19. On [redacted] 2024, Maximus issued the Appellant a Notice of Action. 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 12: Notice of Action)

20. On [redacted] 2024, the Fair Hearing Officer ("FHO") received additional documents from Maximus that included the CTLOC form and copy of the [redacted] 2024 Notice of Action. (Exhibit 11: CTLOC Form and Exhibit 12: Notice of Action)

21. On [redacted] 2024, the FHO reopened the hearing record and requested copies of the medical documentation submitted to Maximus by the facility with the CTLOC Form. On [redacted] 2024, the FHO issued a notice to both the Appellant and Maximus. The record remained open through [redacted] 2024. (Hearing Record)

22. On [redacted] 2024, Maximus forwarded the requested documentation. Refer to Finding of Facts #14 and #15. On [redacted] 2024, the hearing record closed. (Hearing Record)

23. 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. However, the hearing record which was scheduled to close on [redacted] 2024 remained open through [redacted] 2024 to allow Maximus an opportunity to review additional medical information. On [redacted] 2024 the hearing officer reopened the record to obtain additional medical documentation which was not submitted as requested. On [redacted] 2024, the hearing record closed. Due to the [redacted]-day delay, this decision is due not later than [redacted] 2024, 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. **Upon receipt of additional medical documentation from the facility, Maximus correctly completed a new NFLOC for the Appellant and 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. Maximus upheld their original denial of NFLOC on [redacted] 2023. The additional medical documentation provided by the facility does not support the need for continuous skilled nursing services. The Appellant is independent in bathing, dressing eating, toileting, continence, transfer, and ambulation as evidenced by the medical documentation submitted by the facility.**

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

    On [redacted] 2024, Maximus upon completion of a second review, 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.