STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3730

[redacted] 2024
Signature Confirmation

[redacted] [redacted]
[redacted] [redacted]
Request # 231438

NOTICE OF DECISION

PARTY

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

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

PROCEDURAL BACKGROUND

On [redacted] [redacted] 2024, Ascend Management Innovations LLC ("Maximus"), the Department of Social Services contractor that administers approval of nursing home care, sent [redacted] (the "Appellant") a notice of action ("NOA") denying nursing facility ("NF") level of care ("LOC") as not being medically necessary.

On [redacted] 2024, the Appellant requested an Administrative Hearing to contest Maximus's decision to deny NF LOC.

On [redacted] 2024, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] [redacted] 2024, in person at [redacted] (the "Facility").

On [redacted] 2024, the OLCRAH received verbal authorization from the Appellant to update the location of the administrative hearing from in-person to telephone due to the inclement weather.

On [redacted] 2024, in accordance with sections 17b-60, 17-61, and 4-176e to 4-184 inclusive, of the Connecticut General Statutes, OLCRAH held an Administrative Hearing telephonically.

The following individuals participated in the hearing by telephone:

[redacted] Appellant
[redacted] Appellant's Brother
[redacted] Appellant's Sister-in-Law
[redacted] Facility Administrator
[redacted] Facility Social Worker
Mary Perrotti, Department of Social Services, Community Nurse Coordinator
Maximus, Robert Mosteller
Jessica Gulianello, Hearing Officer

The hearing record remained open until the close of business on [redacted] 2024, for the submission of additional documentation from the participants. Additional information was received from the Department, the Facility, and Maximus. The hearing record closed accordingly on [redacted] 2024.

STATEMENT OF THE ISSUE

The issue is whether Maximus correctly denied the Appellant's request for NF LOC approval.

FINDINGS OF FACT

1. The Appellant is [redacted] years old (DOB: [redacted]) and a recipient of long-term care support services. *(Exhibit 6: Level of Care Form – Report Date [redacted]/2024, Hearing Record)*

2. The Appellant had formerly been a recipient of Medicaid services under a Mental Health Waiver. *(Appellant's Sister-In-Law Testimony)*

3. On [redacted] 2023, the Department completed a Universal Care Plan for the Appellant with the assistance of [redacted]. The Department determined that the Appellant met an ADL [activities of daily living] count of 3, and a LON [level of need] count of 5 under the Husky C – Home and Community Based Services Elder Care Waiver Program. The Appellant was approved for the following services beginning [redacted] 2023, through [redacted] 2023:

Service:	Unit or Hours	Frequency
Personal Care Assistant (In-kind)	4 Hours (per day)	7 Times Per week
Skilled Nursing ( )	1.5 Hours	1 Time Per every other month
Personal Care Assistant ( )	4 Hours	7 Times Per week
Care Management	1 Unit	7 Times Per week
Meals Double ( )	1 Unit	5 Times Per week
Annual Cost of All Services (Budget): $57,468.00		

(Exhibit 14: Universal Care Plan dated 2023, Department's Testimony)

4. The Appellant lost more than fifty (50) pounds while residing on her own in an assisted living apartment in the community despite receipt of the above-noted supports and services. *(Appellant's Sister-In-Law Testimony)*

5. On 2023, the Appellant entered the Facility with an admitting diagnosis of . *(Exhibit 6: Level of Care Determination Form, /2024)*

6. The Appellant was admitted into the Facility based on her failure to thrive in the community. (*Appellant's Sister-In-Law Testimony)*

7. The Appellant's medical history includes but is not limited to the following:

█. *(Exhibit 6: Level of Care Determination Form, █/2024, Exhibit 8: Flow Sheets dated █/2024, Hearing Record)*

8. On █ 2023, the Facility submitted the Nursing Facility Level of Care ("NFLOC") screening form to Maximus. The NFLOC screen described the individual's current Activities of Daily Living ("ADLs") support needs as follows: the Appellant required supervision with eating and continuance. For Instrumental Activities of Daily Living ("IADLs"), the Appellant required no assistance with meal preparation and was independent with set up for medications. Maximus granted a short-term approval of █ through █ 2023. (*Hearing Summary, Maximus Testimony*)

9. On █ 2023, the Facility submitted the NFLOC screening form referral to Maximus. The NFLOC screen described the individual's current ADLs support needs as follows: the Appellant required supervision with bathing. For IADLs, the Appellant required verbal assistance with medications and minimal assistance with meal preparation. Based on this information Maximus determined that a medical doctor review was required. (*Hearing Summary, Maximus Testimony*)

10. Maximus received the NFLOC screen, Practitioner Certification, Physical Therapy Notes, Occupational Therapy Notes, Flow Sheets, and MDS. (*Hearing Summary, Maximus Testimony*)

11. On █ 2024, Maximus's medical doctor, █, M.D., reviewed the aforementioned information relating to the Appellant's medical and total needs and he concluded that NFLOC was not medically necessary for the Appellant as she does not require the continuous nursing services delivered at the level of the NF. The Appellant's needs could be met in a less restrictive setting. *(Exhibit 4: ADL Measures and Ratings, Hearing Summary, Maximus Testimony)*

12. Maximus conducted a level I screen and did not conduct a level II Preadmission Screening and Resident Review ("PASRR") on-site screen. *(Hearing Record)*

13. On █ 2024, Maximus issued a NOA to the Appellant and the Facility advising that NFLOC is not necessary for the Appellant. *(Exhibit 5: NOA █/2024, Hearing Summary, Maximus Testimony)*

14. The Appellant's medications include but are not limited to █. *(Exhibit 9: Order Summary Report – █/2023)*

15. The Appellant was seen for an evaluation and subsequent psychotherapy sessions by █ due to the following diagnoses: █

. *(Exhibit 10: Psychiatric Notes: /2023- /2023)*

16. The Appellant requires the use of a walker for assistance with mobility. *(Exhibit 11: Minimum Data Set - dated /2024, Appellant's Testimony)*
17. The Appellant received Occupational Therapy as of 2023. She was later discharged on 2023, after it had been determined that she had achieved the highest practical level. *(Exhibit 12: Occupational Therapy Discharge Summary – /2024)*

18. On 2024, the Facility testified to its documented record of the Appellant's ADL and IADL support needs for the period of 2024, through 2024. *(Exhibit B: Assessment, Facility Testimony)*

19. Maximus requested for the Facility to submit a new NFLOC screening so that a level II PASRR on-site evaluation may be conducted. *(Maximus Testimony)*

20. On 2024, the Facility submitted a new NFLOC to Maximus requesting NFLOC approval for the Appellant effective 2023. *(Exhibit 15: Level of Care Determination Form: /2024)*

21. On 2024, Maximus conducted an onsite assessment interview with the Appellant. (*Exhibit 16: CT Summary of Findings PSRR – /2024*

22. On 2024, Maximus completed the level II onsite PASRR screening and documented their findings (CT Summary of Findings). Maximus noted that the Appellant met the PASRR criteria and was approved with no time limit because she had been diagnosed with with requires routine follow-up with a mental health professional and medication including related to symptoms and behaviors. *(Exhibit 16: CT Summary of Findings PASRR – /2024)*

23. On , 2024, Maximus issued a NOA to the Appellant and the Facility advising that the Appellant was approved for NFLOC based on the PASRR findings without Specialized Services effective 2024. *(Exhibit 17: NOA dated /2024)*

24. The issuance of this decision is timely under Connecticut General Statutes ("Conn. Gen. Stat.") 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 2024. This decision, therefore, was due no later than 2024. However, the hearing record, which had been anticipated to close on 2024, did not close for the admission of evidence until 2024, at the Appellant's request. Because this day delay in the close of the hearing record arose from the Appellant's request, this final decision was not due until 2024, and it is therefore timely. *(Hearing Record)*

CONCLUSIONS OF LAW

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

2. Title 42 of the US Code of Federal Regulations ("USC") § 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.

3. 42 USC § 1396r (e) (7)(A)(i) provides in general effective January 1, 1989, the State must have in effect a preadmission screening program, for making determinations (using any criteria developed under subsection (f)(8)) described in subsection (b)(3)(F) for mentally ill and mentally retarded individuals (as defined in subparagraph (G)) who are admitted to nursing facilities on or after January 1, 1989. The failure of the Secretary to develop minimum criteria under subsection (f)(8) shall not relieve any State of its responsibility to have a preadmission screening program under this subparagraph or to perform resident reviews under subparagraph (B).

4. Section § 17b-259b(a) of the Connecticut General Statutes 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. (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. (c) 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 determining medical necessity.

5. 42 Code of Federal Regulations ("CFR") § 483.102 provides Applicability and definitions as follows: (a) This subpart applies to the screening or reviewing of all individuals with mental illness or intellectual disability who apply to or reside in Medicaid certified NFs regardless of the source of payment for the NF services, and regardless of the individual's or resident's known diagnoses. (b) Definitions. As used in this subpart— (1) An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements on diagnosis, level of impairment and duration of illness: (i) Diagnosis. The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised in 1987. Incorporation of the 1987 edition of the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51 that govern the use of incorporation by reference.[1] This mental disorder is— (A) A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but (B) Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in paragraph (b)(1)(i)(A) of this section.

6. 42 CFR § 483.104 provides as a condition of approval of the State plan, the State must operate a preadmission screening and annual resident review program that meets the requirements of §§ 483.100 through 438.138.

7. 42 CFR § 483.106(a) provides: Basic rule. Requirement. The State PASARR program must require—
    (1) Preadmission screening of all individuals with mental illness or intellectual disability who apply as new admissions to Medicaid NFs on or after January 1, 1989;
    (2) Initial review, by April 1, 1990, of all current residents with intellectual disability or mental illness who entered Medicaid NFs prior to January 1, 1989; and
    (3) At least annual review, as of April 1, 1990, of all residents with mental illness or intellectual disability, regardless of whether they were first screened under the preadmission screening or annual resident review requirements.

8. 42 CFR § 483.126 provides as follows: Appropriate placement. Placement of an individual with MI or IID in a NF may be considered appropriate only when the individual's needs are such that he or she meets the minimum standards for admission and the individual's needs for treatment do not exceed the level of services which can be delivered in the NF to which the individual is admitted either through NF services alone or, where necessary, through NF services supplemented by specialized services provided by or arranged for by the State.

9. 42 CFR § 483.128(a) provides as follows: Level I: Identification of individuals with MI or IID. The State's PASARR program must identify all individuals who are suspected of having MI or IID as defined in § 483.102. This identification function is termed Level I. Level II is the function of evaluating and determining whether NF services and specialized services are needed. The State's performance of the Level I identification function must provide at least, in the case of first time identifications, for the issuance of written notice to the individual or resident and his or her legal representative that the individual or resident is suspected of having MI or IID and is being referred to the State mental health or intellectual disability authority for Level II screening.

10. 42 CFR § 483.132 provides as follows: Evaluating the need for NF services and NF level of care (PASARR/NF).

    (a) Basic rule. 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 an 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.

(b) Determining appropriate placement. 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.

(c) Data. 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).

(d) Based on the data compiled in § 483.132 and, as appropriate, in §§ 483.134 and 483.136, the State mental health or intellectual disability authority must determine whether an NF level of services is needed.

11. Section 17b-262-707(a) of Regulations of Connecticut State Agencies provides that 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 before the department authorizes 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 a mental illness or mental retardation as identified by the preadmission MI/MR screen.

12. Section 17b-262-707(b) of the Regulations of Connecticut State Agencies provides the Department shall pay a provider only when the department has authorized payment for the client's admission to that nursing facility.

On ████ 2024, Maximus issued a Notice of PASRR level II Outcome advising that the Appellant had been approved for NFLOC without Specialized Services effective █████ 2024.

DISCUSSION

In accordance with federal law and Joseph S. v. Hogan, 561 F.Supp.2d 280, 287 (April 21, 2008); states accepting Medicaid funds must have a screening plan, specifically a preadmission screening and resident review (PASRR) plan, to ensure that decisions to place individuals in nursing homes are made appropriately. The Appellant has a medical history of MI (mental illness) that includes but is not limited to the serious diagnoses of ███████ which is a major mental disorder that may lead to chronic disability. Maximus should have identified the Appellant's MI during the Level I screen and subsequently conducted a PASRR Level II evaluation of the Appellant before the issuance of the NOA on ██████ 2024, which advised that NFLOC was not medically necessary. Maximus correctly completed a Level II PASRR on-site evaluation after the Administrative Hearing which substantiated that the Appellant's diagnosis does meet the state's requirements for medical necessity. Maximus correctly issued the Appellant a PASRR Level II Outcome Notice advising that she had been approved for NFLOC with no time limit based on her diagnosis of ███████ which requires routine follow-up with a mental health professional and medication management. However, Maximus incorrectly cited an effective date of █████ 2024, as the evidence confirms that the Appellant's MI diagnosis of ███████ had been reported on the NFLOC screening referral form that the Facility had submitted to Maximus on █████ ██ 2023.

DECISION

The Appellant's appeal is GRANTED.

ORDER

1). Maximus shall grant NFLOC as of [redacted] 2023 without a lapse in the approval.

2). Proof of compliance with this order is due to the undersigned no later than [redacted] 2024.

Jessica Gulianello

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Jessica Gulianello
Hearing Officer

Cc: [redacted]
[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, law, and 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 requested 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 the Department of Social Services, Director, Office of Administrative Hearings and Appeals, 55 Farmington Avenue, Hartford, CT 06105-3725.

RIGHT TO APPEAL

The appellant has the right to appeal this decision to the 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 if 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 06105-3725. A copy of the petition must also be served to 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 following §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.