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 # 232037

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2024, 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] 2024, 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 at the facility.

On [redacted] 2024, OLCRAH changed the in person hearing at the facility to a telephone hearing and granted a continuance in order to reschedule the administrative hearing.

On [redacted] 2024, the 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 via teleconference.

The following individuals participated in the hearing:

[redacted] Appellant
[redacted] Director of Social Work Services, [redacted]
Robert Mostellar, Lead Clinical Coordinator, Maximus Representative
Patricia Jackowski, RN MA, Department Representative
Lisa Nyren, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Maximus's [redacted] 2024 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 with an admitting diagnosis that included unspecified fracture of upper end of left humerus, subsequent encounter for fracture with routine healing, systemic inflammation response syndrome ("SIRS") of non-infectious origin without acute organ dysfunction, Covid-19, sepsis, hypertension, Type 1 diabetes mellitus without complication, alcohol use, and unspecified injury of head. (Exhibit 3: Hearing Summary, and Exhibit 6: Level of Care Determination Form)

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

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. Upon admission to the facility, Maximus authorized a 120-day short-term NFLOC which expired on [redacted] 2023. (Exhibit 3: 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 short-term stay of 61-90 days at the facility beginning [redacted] 2023. 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 hypertension, type 2 diabetes mellitus with diabetic neuropathy, unspecified hyperlipidemia, unspecified adjustment disorder, alcohol use, SIRS, unspecified injury of head, unspecified fracture of upper end of left humerus. The facility lists skilled nursing services as: speech therapy, physical therapy occupational therapy PRN, labs and vitals monitoring, mood and behavior monitoring, pain management, medication management and supervision of ADL's. The facility lists the Appellant's functional capabilities for bathing, dressing, eating, toileting, mobility, transfer, and continence as independent or supervision less than daily commenting, "Resident is mostly independent with his ADLs. He just needs some supervision at times to make sure his ADLs are completed safely and efficiently." 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)

6. 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, [redacted] 2023/[redacted] 2024 Activities of Daily Living ("ADL") Flow Sheets, Physicians Order Summary Report, Progress Note, Minimum Data Set ("MDS"), and discharge summaries from physical therapy and occupational therapy. (Hearing Record)

7. The ADL Flow Sheets for period [redacted] 2023 through [redacted] 2024 lists the Appellant independent with minimal set up bathing/showering, oral hygiene and eating. The ADL Flow sheets document the Appellant independent in bed mobility, transfer, dressing, personal hygiene and toileting. (Exhibit 8: ADL Flow Sheets)

8. The Physicians Order Summary Report lists dietary restrictions as low concentrated sweets/no added salt and medication management for diabetes, hypoglycemia, hypertension, pain, and bowel movements. Therapies (speech, physical, and occupational) are authorized as indicated. (Exhibit 9: Order Summary Report)

9. The [redacted] 2023 progress note cites, "This is a[n] individual with multiple chronic conditions which are notable. The patient is currently in no distress and is stable." The assessment notes the following: hypertensive heart disease, Wernicke syndrome, and hyperlipidemia unspecified. Treatment plan lists medication adjustments to address hypertensive heart disease, encourage patient to avoid alcohol but continue to monitor cognitive status and gait, and hyperlipidemia continue to monitor medication and any neurologic changes. (Exhibit 10: Progress Note)

10. The Appellant received occupational therapy ("OT") services at the facility between [redacted] 2023 and [redacted] 2023. OT discharged the Appellant from their services after receiving "highest practical level achieved." As of [redacted] 2023, the OT completed a functional assessment noting the Appellant independent in eating, oral hygiene, toileting hygiene, toilet transfer, and personal hygiene, however requiring supervision for bathing and dressing. (Exhibit 11: Occupational Therapy Discharge Summary)

11. The Appellant received physical therapy ("PT") services at the facility between [redacted] 2023 and [redacted] 2023. PT notes the Appellant independent with bed mobility, transfers, ambulation, and stairs/curbs. PT discharged the Appellant after receiving "highest practical level achieved" noting re-evaluation may be necessary once discharge location is secured. PT commented, "client is at a decrease fall risk with use of rollator walker compared to cane use." (Exhibit 13: Physical therapy Discharge Summary)

12. On [redacted] 2023, the facility completed the MDS which describes the functional status and cognitive patterns of the Appellant. The partial report submitted lists bed mobility and transfers with one person assist and eating and toileting as set up help. (Exhibit 11: MDS)

13. 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)

14. Upon review of the LOC determination form, Practitioner Certification, ADL Flow Sheets, Order Summary Report, Progress Note, MDS, and OT/PT Discharge Summaries, 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. (Hearing Record)

15. On [redacted] 2024, 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)

16. The Appellant suffers from diabetic neuropathy which has impacted his ability to stand or walk for long periods of time. The Appellant walks slowly and stops frequently because his legs feel like they will give out. The Appellant uses a cane and a rollator when moving about the facility. His arms continue to hurt, and he does not have full rotation of his left arm. Since discharged from therapies, he tries to follow his exercise plan. The Appellant continues to suffer with indigestion and irregular bowel movements. (Appellant Testimony)

17. The Appellant seeks a continued stay at the facility since he has not been able to secure appropriate housing that can meet his needs. The Appellant is working with Money Follows the Person but does not feel it is safe for him in the community due to his risk of falling and inability to walk or stand for period of time longer than 15 minutes. (Appellant's Testimony)

18. 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] 2024. Therefore, this decision is due not later than [redacted] 2024.

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. The Appellant is independent in his activities of daily living with minimal support provided infrequently as evidenced by the medical documentation submitted by the facility. Although the Appellant is concerned for his safety upon discharge due to limitations in his ability to stand for long periods, PT discharge notes the Appellant is at a decrease fall risk with the use of the rollator rather than a cane.

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.