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

[redacted] 2022
Signature Confirmation

Client ID [redacted]
Case ID [redacted]
Request # 195655

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2022, 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] 2022 prior authorization request for nursing facility level of care ("NFLOC") as not medically necessary.

On [redacted] 2022, the Appellant requested an administrative hearing to contest Maximus's decision to deny NFLOC.

On [redacted] 2022, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2022.

On [redacted] 2022, 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] Social Worker, [redacted]
Jean Denton, LPN, Maximus Representative, participated by telephone
Charles Bryan, MBA, MSN, RN, Department of Social Services Representative
Lisa Nyren, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Maximus's [redacted] 2022 decision to deny the facility's [redacted] 2022 request for a NFLOC determination on behalf of the Appellant as not medically necessary was correct.

FINDINGS OF FACT

1. On [redacted] 2020, [redacted] ("hospital") admitted the Appellant with an admitting diagnosis of pressure ulcer of the upper thigh. (Hearing Record)

2. On [redacted] 2020, the facility, a skilled nursing facility, admitted the Appellant with an admitting diagnosis rhabdomyolysis, cord compression, paraplegia, and wounds from the hospital. The Appellant received a 30-day exempted hospital discharge certifying the Appellant meets the NFLOC for a 30-day stay at the facility. (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. (Hearing Record)

4. On [redacted] 2020, the facility submitted the Connecticut Level of Care Form ("CTLOC determination form") to Maximus requesting a nursing facility level of care ("NFLOC") approval for the Appellant's stay at the facility which Maximus approved. Maximus authorized a 120-day short term stay expiring on [redacted] 2020. (Hearing Record)

5. On [redacted] 2020, the facility submitted the CTLOC determination form to Maximus requesting a NFLOC approval for the Appellant's stay at the facility which Maximus approved. Maximus authorized a 180-day short term stay expiring on [redacted] 2021. (Hearing Record)

6. On [redacted] 2021, , the facility submitted the CTLOC determination form to Maximus requesting a NFLOC approval for the Appellant's stay at the facility which Maximus approved. Maximus authorized a 90-day short term stay expiring on [redacted] 2021. (Hearing Record)

7. On [redacted] 2021, the facility submitted the CTLOC determination form to Maximus requesting a NFLOC approval for the Appellant's stay at the facility which Maximus approved. Maximus authorized a 180-day short term stay expiring on [redacted] 2022. (Hearing Record)

8. On [redacted] 2022, the facility submitted the CTLOC determination form to Maximus requesting a NFLOC approval for the Appellant's stay at the

facility which Maximus approved. Maximus authorized a 60-day short term stay expiring on [redacted] 2022. (Hearing Record)

9. On [redacted] 2022, the facility submitted the CTLOC determination form to Maximus requesting NFLOC approval on behalf of the Appellant for a continued stay of 61-90 days at the facility beginning [redacted] 2022. (Exhibit 6: LOC Determination Form)

10. The facility submitted supporting documentation with the CTLOC determination form. The supporting documents included the Practitioner Certification signed on [redacted] 2022 attesting the Appellant meets NFLOC, Completed Care Details, Physician's Orders, Minimum Data Sets ("MDS"), Psychiatry Notes, LTC Physicians Orders, Progress Notes, and Collaborative Lab Services. (Hearing Record)

11. Completed care details for the period [redacted] 2022 through [redacted] 2022 indicate the Appellant as independent in bed mobility, transfer, walk in her room, walk in the corridor, and toileting with no set-ups or physical help from staff. The Appellant can dress without set-ups or physical help from staff except on three (3) occasions where the Appellant required set up on [redacted] 2022 and [redacted] 2022 and supervision on [redacted] 2022. The Appellant is independent with personal hygiene except on two (2) occasions [redacted] 2022 and [redacted] 2022 where supervision was provided. The Appellant is independent with bathing except on five (5) occasions with set up help and on [redacted] 2022 with a one person assist. The set up and/or assistance provided by facility staff was due to staff choosing to bathe the Appellant rather than showering because the facility showers were not available. The Appellant is independent in eating, except on eleven (11) occasions. Because the Appellant eats her meals in her room, rather than the facility dining room, set up help is provided by staff who deliver the tray of food. (Exhibit 8: Completed Care Details, Social Worker Testimony, and Appellant's Testimony)

12. The MDS describes the functional status of the Appellant. The Appellant is independent in bed mobility, transfers, mobility which includes walk about room and corridors, and toileting. Based on the MDS, the Appellant requires set up support with dressing, eating, and personal hygiene. The Appellant requires supervision with bathing. The Appellant uses both a wheelchair and walker to move about the facility. The Appellant wears ankle-foot orthoses ("AFO's") to support her feet and ankles due to muscle and nerve damage and assist in stabilization while transferring or walking about. The facility conducted a Brief Interview for Mental Status ("BIMS") with the Appellant. The facility noted no changes in the Appellant's cognitive functioning. (Exhibit 10: MDS, Exhibit 11: Physician Orders, Social Worker's Testimony, and Appellant's Testimony)

13. The Appellant's diagnosis includes depression, anxiety, with agitation, and irritability. The Appellant meets with the facility's lead clinical social worker weekly for support. The Appellant's anxiety has increased as she nears discharge because she does not have a place to live. Prior to placement at the facility, the Appellant resided with her mother. However, she is not able to her mother's home since her mother now requires NFLOC. (Appellant's Testimony and Exhibit 9: Psychiatry Notes)

14. Beginning [redacted] 2021, the Appellant received occupational therapy ("OT") three times per week for four weeks which included therapeutic exercise and activities, neuromuscular re-education, weight control management, self-care management training, and wheelchair management. (Exhibit 13: LTC Physician Orders and Exhibit 16: Occupational Therapy Notes)

15. Beginning [redacted] 2021, the Appellant received physical therapy ("PT") three times per week for four weeks which included therapeutic exercise and activities, neuromuscular re-education, gait training therapy, and group therapeutic procedures. (Exhibit 13: LTC Physician Orders and Exhibit 14: Physical Therapy Notes)

16. The Appellant no longer receives occupational therapy ("OT") and physical therapy ("PT"). The Appellant spent eight (8) months in bed upon her admission to the facility recovering. Due to damage in the muscles in her legs, the wound on her upper thigh, and neuropathy in her feet, she was not able to stand and required substantial care at the facility at time of admission. (Appellant's Testimony and Social Worker's Testimony)

17. Upon review of the LOC form, the Practitioner Certification, Completed Care Details, Physician's Orders, MDS, Psychiatry Notes, LTC Physician's Orders, Progress Notes, and Collaborative Lab Services results, Maximus determined the Appellant did not meet nursing facility LOC 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 nursing facility LOC 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)

18. On [redacted] 2022, 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)

19. The Appellant is independent with the following activities of daily living ("ADL's"): dressing, eating/feeding, toileting, mobility, transfers, and continence. The Appellant needs support getting in and out of the shower without a walker and AFO's. With transfer support, handrails, and a shower bench, the Appellant can shower on her own. (Appellant's Testimony)

20. The facility monitors and treats the Appellant's blood glucose levels through medication and lab work. The Appellant participated in diabetes education with the facility in preparation for her discharge. The Appellant can monitor her blood glucose levels. The Appellant's blood sugar levels have fluctuated, but the Appellant admits to eating candy occasionally which can affect her blood sugar levels. (Social Worker's Testimony and Appellant's Testimony)

21. The Appellant's wounds have healed, but neuropathy remains in her feet with limited muscle strength in her legs. (Appellant's Testimony)

22. The Appellant walks the facility corridors daily for exercise. The Appellant walks up to four times per day. With the use of the walker, the Appellant can stand up to one hour at a time. (Appellant's Testimony)

23. The Appellant would like to return to the community but needs supports, such as the Visiting Nurse Association ("VNA") to complete her daily activities. The Appellant does not have accessible family support in the community. The Appellant feels confident in managing her diabetes and making good food choices. The Appellant requests assistance with showering, medication, transportation, and grocery shopping. (Appellant's Testimony)

24. 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] 2022. Therefore, this decision is due not later than [redacted] 2022 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. **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. The Appellant reports she needs supports when entering and exiting the shower, but with grab bars/handrails and shower seating, the Appellant can independently shower. Although the MDS reports the Appellant requires set-up supports with dressing, eating, personal hygiene and supervision with bathing, the completed care plan and testimony provided at the hearing does not support this. The facility provided set-up support for two occasions and supervision on one occasion during a two week period. Testimony provided confirms the Appellant independent with eating as the support provided by the facility was due to the Appellant's choice to eat in her room where staff deliver meals to resident's room rather than consuming their meals in the dining hall. Because showers were not available, the facility chose to bathe residents resulting personal hygiene set up assistance and bathing assistance for residents. Additionally, the Appellant is not participating in any therapies, occupational or physical, currently. Such sporadic and limited services do not require placement in a skilled nursing facility but can be provided in the community.**

    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.

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

DECISION

The Appellant's appeal is denied.

Lisa A. Nyren
Lisa A. Nyren
Fair Hearing Officer

CC: DSS Community Options Division
MaximusCTadminhearings@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.