

- Ascend 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. Ascend determined the Appellant's needs could be met in a less restrictive setting. (Exhibit 3: Hearing Summary, Exhibit 5: Notice of Action, Exhibit 6: LOC Determination Form, Exhibit 7: Practitioner Certification, Exhibit 8: History and Physical, Exhibit 9: Minimum Data Set, Exhibit 10: MAR, Exhibit 11: Physician's Order Sheet, and Exhibit 12: ADL Look Back Report)
8. On ██████████ 2021, , Ascend issued a notice of action to the Appellant. The notice stated Ascend determined that "nursing facility level of care is not medically necessary for you at this time. ... 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)
 9. The Appellant is independent with most activities of daily living ("ADL's") and instrumental activities of daily living ("IADL's") except bathing/showering where he requires assistance washing his back and legs due to limitations when bending and inability to lift legs when washing. The Appellant requires no assistance with maintaining proper hygiene and minimal assistance dressing, specifically requests assistance with compression socks. The Appellant requires no assistance with eating, toileting and continence. The Appellant is able to walk and transfer independently and is independent with medication management. (Exhibit 6: LOC Determination Form, Exhibit 7: Practitioner Certification, Exhibit 8: History and Physical, Exhibit 9: Minimum Data Set, Exhibit 10: MAR, Exhibit 11: Physician's Order Sheet, Exhibit 12: ADL Look Bank Report, and Appellant's Testimony)
 10. The Appellant's health has improved since admission. (Hearing Record)
 11. The Appellant wishes to extend his stay at the facility because he has not located housing. The Appellant is working with Money Follows the Person ("MFP"), a program to assist residents in long-term care facilities to transition to the community. If discharged prior to locating housing, the Appellant loses his eligibility under the MFP program. (Appellant's Testimony and Social Worker's Testimony)
 12. 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 ██████████ 2021. Therefore, this decision is due not later than ██████████ 2021.

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. Stats. § 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 required health service shall be 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. The Appellant does not require continuous skilled nursing services for an uncontrolled or unstable chronic condition or supervision for a chronic condition requiring substantial assistance on a daily basis.
14. Ascend correctly denied the facility's request for LOC review on behalf of the Appellant as not medically necessary, as defined by section 17b-259b(a) of the Connecticut General Statute.
15. Ascend was correct in its determination that the Appellant does not meet the medical criteria for nursing home level of care.

DECISION

The Appellant's appeal is denied.



Lisa A. Nyren
Fair Hearing Officer

CC: DSS Community Options Division
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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.