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 # 192087

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 stating that the request for a nursing facility level of care ("LOC") review submitted by your healthcare professional was not processed because the LOC screen was withdrawn by your health care professional.

On [redacted] 2022, the Appellant requested an administrative hearing to contest the Maximus' decision to deny nursing facility LOC.

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 via teleconference.

The following individuals called in for the hearing:

[redacted] Appellant
[redacted] Social Worker, [redacted]
[redacted] Director of Social Work, [redacted]

Paul Cook, Maximus
Allison Weingart, Community Options, Department Representative
Stacy Bent, RN, Community Options, In Training
Lisa Nyren, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Maximus' decision to deny the nursing facility's request for a LOC determination on behalf of the Appellant was correct.

FINDINGS OF FACT

1. On [redacted] 2021, [redacted] (the "facility"), a skilled nursing facility, admitted the Appellant to their facility. (Hearing Record)

2. Maximus is the Department's contractor that determines if a patient meets nursing facility LOC ("NFLOC") criteria to authorize payment under Medicaid. (Hearing Record)

3. On [redacted] 2021, Maximus determined the Appellant met NFLOC approving a sixty (60) stay at the facility which expired on [redacted] 2021. (Hearing Record)

4. On [redacted] 2021, the facility submitted an online prior authorization request to Maximus for NFLOC approval for the Appellant's continued stay at the facility. (Stipulated)

5. On [redacted] 2021, the facility submitted the Practitioner Certification form signed by [redacted] on [redacted] 2021 attesting that the Appellant meets NFLOC. (Exhibit 6: Practitioner Certification)

6. On [redacted] 2021, Maximus submitted an online request to the facility for additional information, specifically CNA flow sheets, history of physical exam, and Section G of the minimum data sets ("MDS"). (Stipulated)

7. On [redacted] 2021, the facility submitted the following documents online to Maximus: Resident Personal Care Records dated [redacted] 2021 through [redacted] 2021, [redacted] 2021 Resident Progress Notes , Section G MDS [redacted] 2021. (Stipulated)

8. The facility completes MDS quarterly. At the time of the [redacted] 2021 NFLOC submission, the [redacted] 2021 MDS was the most recent

on file with the facility because the facility completes the MDS quarterly. (Director of Social Work's Testimony)

9. The facility failed to submit a current MDS to Maximus for review. Without a current MDS, Maximus cannot make a NFLOC determination resulting in Maximus cancelling the NFLOC request made by the facility, citing a technical denial. (Maximus Representative's Testimony)

10. On [redacted] 2022, Maximus issued the Appellant a Notice of Level of Care Determination ("LOC Notice") to the Appellant. The notice lists the LOC determination as "Cancelled." Maximus writes, "Your health care professional submitted a request for nursing facility level of care on your behalf. This notice is to inform you that Maximus is not processing this request because your level of care screen was withdrawn by your health care professional. ... Your request for screening may be resubmitted at any time." Maximus included appeal rights and a hearing request form with the notice. (Exhibit 5: Notice of LOC Determination)

11. On [redacted] 2022, Maximus posted a copy of the LOC Notice online. Facilities have access to all notices issued through the online system used by Maximus and nursing facilities for LOC determinations. (Maximus Representative's Testimony)

12. The facility did not resubmit their request to Maximus for a NFLOC determination after receiving the denial. (Director of Social Work's Testimony)

13. Maximus did not notify the facility that the [redacted] 2021 Section G MDS was not acceptable because it was too old. (Maximus Representative's Testimony)

14. The facility may resubmit their NFLOC requesting retroactive coverage. (Maximus Representative's Testimony)

15. 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.

CONCLUSIONS OF LAW

1. Section 17b-2(6) of the Connecticut General Statutes ("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-262-703 of the Regulations of Connecticut State Agencies ("regs., Conn. State Agencies") provides as follows:

   In order to enroll in the Medicaid program and receive payment from the department, a nursing facility shall comply with sections 17b-262-522 through 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies. Licensing and certification requirements for nursing facilities referenced in sections 17b-262-701 to 17b-262-711, inclusive, of the Regulations of Connecticut State Agencies include, but are not limited to, the criteria described in section 19-13-D8t of the Regulations of Connecticut State Agencies and the criteria described in 42 CFR Part 483, subpart B, as amended from time to time.

   "Payment for nursing facility services is available to all persons eligible for the Medicaid program subject to the conditions and limitations that apply to these services." Regs., Conn. State Agencies § 17b-62-704

3. State statutes 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)

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)

State regulation provides as follows:

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 goods and services.

Regs., Conn. State Agencies § 17b-262-527

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)

4. “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 goods and services.” Regs., Conn. State Agencies § 17b-262-527

   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)

5. State regulation provides as follows: The department shall pay for an admission that is medically necessary and medically appropriate as evidence 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 readmission screening level II evaluation for any individual suspected of having mental illness or mental retardation as identified by the preadmission MI/MR screen.

    Regs., Conn. State Agencies § 17b-262-707(a)

    State regulation provides as follows:

    Patients shall be admitted to the facility only after a physician certifies the following:

    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 personal care, on a daily basis.

    Regs., Conn. State Agencies § 19-13-D8t(d)(1)(A)(i)

6. 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)

State regulation provides as follows:

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)

"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)

7. 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)

"The department's uniform policy manual is the equivalent of a state regulation and, as such, carries the force of law." *Bucchere v. Rowe,* 43 Conn. Supp. 175, 178 (1994) (citing Conn. Gen. Stat, § 17b-10; *Richard v. Commissioner of Income Maintenance,* 214 Conn. 601, 573 A.2d 712(1990))

Section 1555.25(A) of the Uniform Policy Manual ("UPM") provides as follows:

Assistance units incurring a change in circumstances are notified of actions taken by the Department which affect eligibility or benefit level.

"The Department must tell the assistance unit what the unit has to do to establish eligibility when the Department does not have sufficient information to make an eligibility determination." UPM 1015.05(C)

"The Department must inform the assistance unit regarding the eligibility requirements of the programs administered by the Department, and regarding the unit's rights and responsibilities." UPM § 1015.10(A)

"In the Medicaid program, the Department sends adequate notice no later than the date of the action, under the following situations, as well as under those described in paragraph 1: the unit member's physician prescribes a change in the unit members level of care." UPM § 1570.10(B)(4)(b)

Maximus failed to issue a proper notice to the Appellant. Maximus failed to provide a copy of the specific guideline or criteria upon the denial of the prior authorization request for NFLOC to the Appellant. Maximus failed to complete a NFLOC review, instead cancelling their review citing the LOC screen was withdrawn by the facility. The facility did not withdraw their prior authorization request for NFLOC as supported by the hearing record. Maximus failed to inform the Appellant, and the facility, the eligibility requirements necessary to complete a NFLOC determination, specifically a <u>current</u> MDS. Although a facility should know the medical documentation needed for Maximus to make a proper NFLOC, Department policy provides that the Department must tell the assistance unit what it must do to establish eligibility when the Department does not have sufficient information to make an eligibility determination. Maximus, a Department contractor, must follow Department policy and Maximus failed to inform the Appellant, and the facility, additional specific medical documentation was needed to process the prior authorization request.

On [redacted] [redacted] 2022, Maximus incorrectly denied the [redacted] [redacted] 2021 prior authorization request for NFLOC.

DECISION

The Appellant's appeal is GRANTED.

ORDER

1. Maximus must reopen the facility's [redacted] 2021 prior authorization request for NFLOC on behalf of the Appellant and inform the Appellant and the facility the information needed to make a proper NFLOC determination.

2. Compliance is due 10 days from the date of this decision.

Lisa A. Nyren
Lisa A. Nyren
Fair Hearing Officer

CC: Department of Social Services, Community Options Unit
Maximus
[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 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.