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 # 197987

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") on behalf of the Appellant 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 by teleconference at the Appellant's request.

The following individuals called in for the hearing:

[redacted], Appellant
[redacted], Bookkeeper, [redacted]
Jean Denton, LPN, Maximus Representative

Stacy Bent, 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], 2022, [redacted] (the "facility"), a skilled nursing facility, admitted the Appellant with an admitting diagnosis autoimmune hepatitis, bradycardia, anemia, thrombocytopenia unspecified, dizziness/giddiness, unspecified cirrhosis of the liver, hypo-osmolality, hyponatremia, esophageal varices without bleeding, and portal hypertension. (Maximus Representative's Testimony, Exhibit 3: Hearing Summary, and Exhibit 6: LOC Determination Form)

2. Autoimmune hepatitis is a disorder which attacks the liver. The body's immune system targets the liver causing damage to liver cells and compromising an individual's immune system where an individual is susceptible to infections and/or viruses such as colds, the flu, or Covid-19. Autoimmune hepatitis can cause cirrhosis of the liver resulting in permanent damage to the liver. (Maximus Representative's Testimony)

3. Bradycardia is a slow heart rate which can cause dizziness. Anemia is a low red blood cell count. Risk of anemia can increase with hepatitis. Thrombocytopenia unspecified is a condition in which an individual has a low blood platelet count in their bone marrow. Portal hypertension refers to high blood pressure. (Maximus Representative's Testimony)

4. Hypo-osmolality refers to a condition where the levels of electrolytes are imbalanced. Hyponatremia refers to a condition where the level of salt/sodium is low specifically. Such conditions can lead to fluid build-up. (Maximus Representative's Testimony)

5. Esophageal varices without bleeding refers to ulcers located in the esophagus. (Maximus Representative's Testimony)

6. The Appellant experiences pain in his liver and kidneys. The Appellant experiences periods of weak muscles where he is unable to get out of bed without assistance after having had COVID-19 in [redacted] 2022. The Appellant's diet includes low salt meals. (Appellant's Testimony)

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

8. The Appellant received six occupational therapy ("OT") sessions between [redacted] 2022 and [redacted] 2022 to address generalized muscle weakness. Short term goals included sustained standing tolerance to access bathroom for toileting task without impairment and independent with sitting bathing task. Long-term goals included sustained standing tolerance with no impairment using a cane for 15 minutes to complete bathing task and shower task with shower chair and perform toileting routine independent with adaptive/assistive devices. On [redacted] 2022, OT discharged the Appellant as all short-term and long-term goals were met. OT status update as of [redacted] 2022 lists the Appellant as independent with feeding, upper body and lower body bathing and dressing as independent, hygiene and grooming independent, toileting, bed mobility, and transfers independent. (Exhibit 14: Occupational Therapy Discharge Summary and Exhibit 15: Occupational Therapy Treatment Encounter)

9. 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)

10. On [redacted] 2022, the facility submitted the Connecticut Level of Care Form ("LOC determination form") to Maximus requesting NFLOC approval on behalf of the Appellant for a continued stay of 91-120 days at the facility beginning [redacted] 2022. 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. The facility lists skilled nursing services as: monitor weights, labs, vital signs, potassium tablet monitoring, pressure-redistribution mattress to bed, and pressure-redistribution cushion to chair. The facility lists the Appellant requires supervision daily for bathing and dressing and independent or supervision less than daily for eating, toileting, mobility, transfer, and continence. The facility writes, "Patient needs more time at SNF because he has nowhere safe to discharge to. Looking for housing through the MFP program." (Exhibit 6: LOC Determination Form)

11. The facility submitted supporting documentation with the LOC determination form. The supporting documents included the Practitioner Certification signed on [redacted], 2022 attesting the Appellant meets NFLOC, Order Summary Report as of [redacted] 2022, Documentation Survey Report for [redacted], Physical Therapy Discharge Summary,

Progress Notes, Physical Therapy Treatment Encounter Note, Minimum Data Sets ("MDS"), Occupational Therapy Discharge Summary, Occupational Therapy Treatment Encounter Note, and Progress Notes [redacted] 2022. (Hearing Record)

12. Order Summary Report as of [redacted] 2022 lists current and active orders which include weekly Norton plus/Braden scale checks, monitor for pain, weekly shower, weight checks while on diuretic, and medications as ordered by the attending physician. (Exhibit 8: Order Summary Report)

13. Documentation Survey Report for [redacted], 2022 through [redacted], 2022. During this period, the Appellant required no assistance with showering or tub bathing. The Appellant required limited assistance on three occasions with bed mobility and supervision with two occasions. During this period the Appellant required supervision with dressing on three occasions and limited assistance dressing once. On one occasion the Appellant required supervision in locomotion on and off the unit. On three occasions the Appellant required supervision in completing personal hygiene activities and one occasion with limited assistance. On four occasions the Appellant required supervision when toileting. On three occasions the Appellant required supervision when transferring and one occasions limited assistance. On five occasions the Appellant required supervision when walking in the hallway and nine occasions where supervision was provided when walking in his room. The facility provided supervision at mealtime. (Exhibit 9: Documentation Survey Report)

14. Between [redacted] 2022 and [redacted] 2022, the Appellant received three physical therapy sessions which included therapeutic exercise. Physical therapy discharged the Appellant on [redacted] 2022 after reaching his "highest potential level with skilled services." Physical therapy recommends the Appellant continue with his exercise program. (Exhibit 10: Physical therapy Discharge Summary and Exhibit 12: Physical Therapy Treatment Encounter)

15. [redacted] 2022 progress note cite, "This patient is well developed and in no acute distress." The treatment plan lists, "Autoimmune hepatitis/cirrhosis-weight has been trending up which could be secondary to both fluid and also excess calorie consumption. Continue prednisone, prograf CellCept, Valcyte, Protonix and Bactrim. Increase Lasix to 40 mg. Continue spironolactone. Check chemistry on Monday. We will wean Dilaudid to every 6 hours with plan to wean to every 8 hours in the coming weeks. Follow-up with GI. Hypertension – stable. Continue Furosemide and Spironolactone with parameters. Continue Potassium Chloride Constipation-stable. Continue miralax. Continue as needed regimen." (Exhibit 11: Progress Notes)

16. The MDS describes the functional status of the Appellant. The facility completed the MDS with the Appellant on [redacted] 2022. The Appellant is independent in bed mobility, transfers, mobility/locomotion, and dressing. The Appellant received set up assistance only for eating, toileting, personal hygiene, and bathing. The facility notes the Appellant is steady with balance during transition from seated to standing, walking, turning while walking, moving on and off the toilet and transfers between bed and chair. The facility notes no impairment in range of motion. The Appellant uses a cane to move about the facility. The facility conducted a Brief Interview for Mental Status ("BIMS") with the Appellant scoring a 15 out of 15. The facility noted no evidence of change in the Appellant's mental status. (Exhibit 13: Minimum Data Set)

17. Upon review of the LOC form, the Practitioner Certification, Order Summary Report as of [redacted] 2022, Documentation Survey Report for [redacted] 2022, Physical Therapy Discharge Summary, Progress Notes, Physical Therapy Treatment Encounter Note, MDS, Occupational Therapy Discharge Summary, Occupational Therapy Treatment Encounter Note, and Progress Notes [redacted] 2022, 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], 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 continues to exercise three times per week in the physical therapy room where he is monitored by staff. The Appellant seeks to build up his strength to ensure a safe discharge back into the community. (Appellant's Testimony)

20. The Appellant uses a walker and/or cane to move about his room and the facility. (Appellant's Testimony)

21. The Appellant requests help when showering because he cannot stand for a long period of time. The Appellant does not use a shower chair to

assist. Sometimes the Appellant requests help with dressing, specifically putting on his shirt and socks. (Appellant's Testimony)

22. The Appellant's appetite decreases when he experiences abdominal pain due to liver disease and may go a few days without eating. (Appellant's Testimony)

23. 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. Although the Appellant reports occasional difficulty with dressing, showering, and transfers, the Appellant is not participating in any therapies, occupational or physical, currently. Medical documentation provided by the facility does not support the need for continuous skilled nursing services as such sporadic and limited services such as monitor weights, labs, vital signs, potassium tablet monitoring, pressure-redistribution mattress to bed, and pressure-redistribution cushion to chair provided by the facility can be provided in the community. The Appellant continues to work on strength, but remains independent in bathing, dressing eating, toileting, continence, transfer, and ambulation with the use of a cane/walker as evidenced by the medical documentation submitted by the facility.**

    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.