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

[redacted], 2023
Signature Confirmation

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

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2022, Ascend Management Innovations LLC ("Maximus"), the Department of Social Services ("Department") contractor that administers approval of nursing home care, sent [redacted] ("Appellant") a Notice of Action ("NOA") denying Medicaid coverage for nursing facility level of care.

On [redacted], 2022, the Appellant requested an administrative hearing to contest Maximus' decision to deny Medicaid coverage for nursing facility level of care.

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 4-184, inclusive, of the Connecticut General Statutes, the OLCRAH held an administrative hearing at [redacted]. The following individuals participated in the hearing:

[redacted], Appellant
Michael Heaven, Facility Social Worker, [redacted]
Jean Denton, Supervisor-Clinical Management, Maximus Representative

Charlaine Ogren, LCSW, Department's Representative
Joseph Davey, Administrative Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Maximus' decision to deny the Appellant's Medicaid coverage for nursing facility level of care was correct.

FINDINGS OF FACT

1. The Appellant is [redacted] ([redacted]) years old [DOB [redacted].] (Appellant's Testimony)

2. The Appellant is a recipient of Medicaid. (Hearing Record)

3. On [redacted], 2022, the Appellant was admitted to [redacted] ("Facility") with the following diagnosis: ethyl alcohol ("ETOH",) abuse with withdrawal, hypertension ("HTN",) major depressive disorder, ETOH induced acute pancreatitis and chronic coronary artery disease. He received a 30-day exempted hospital discharge which expired on [redacted], 2022. (Hearing Record, Maximus' testimony)

4. On [redacted], 2022, the Facility submitted a NFLOC screening form to Maximus for review. The NFLOC form described the Appellant's current Activities of Daily Living ("ADL's") as requiring supervision with bathing and current Instrumental Activities of Daily Living ("IADL's") as requiring physical assistance with medications and minimal assistance with meal preparation. After review, Maximus determined a Level 1 screen was necessary and recommended a medical doctor conduct a review. During the review it was noted the Appellant was able to perform his ADLs independently and that his needs could be met in the community with appropriate supports. The appropriate supports included intermittent assistance through home health, visiting nurse, or some other venue to monitor his condition. (Hearing Record)

5. On [redacted], 2022, Dr. William Regan MD, the medical doctor for Maximus, assessed the Appellant's medical condition using the following: NFLOC screen, Practitioner Certification, Physical Therapy Note, Nurses Notes, Progress Note, Physician Orders, Face Sheet, Interdisciplinary Rehabilitation Screening, Trident Care Lab Report, Harvest Prescribers Note and Completed Care Detail Report, Dr. Regan determined that nursing facility level of care was not medically necessary for the Appellant as it is not clinically appropriate in terms of the level of services provided and is not considered effective for his condition. Dr. Regan found that the Appellant's needs could be met through a combination of medical, psychiatric and social services provided outside the nursing facility setting. (Exhibit 4: ADL Measures and ratings, Exhibit 6: Level of Care Determination dated [redacted],

Exhibit 7: Practitioner Certification dated [redacted], Exhibit 8: Physical Therapy Notes for period [redacted], Exhibit 9: Completed Care Details dated [redacted], Exhibit 10: Nurses Notes for period [redacted], Exhibit 11: Physician Orders dated [redacted], Exhibit 12: [redacted] Lab Report dated [redacted], Exhibit 13: Progress Note dated [redacted], Exhibit 14: [redacted] Prescriber Note dated [redacted], Exhibit 15: Interdisciplinary Rehabilitation Screening dated [redacted], Exhibit 16: Face Sheet dated [redacted], Hearing Record)

6. On [redacted], 2022, Maximus issued a NOA to the Appellant informing him that he does not meet the criteria necessary for nursing facility level of care. (Exhibit 5: Notice of Action dated [redacted])

7. On [redacted], 2022, the OLCRAH received the Appellant's hearing request form. (Exhibit 1: Notice of Administrative Hearing dated [redacted])

8. The Appellant has some limited issues with bladder control, medication management and meal preparation but is otherwise independent with his ADL's and IADL's. (Exhibit 9, Appellant's testimony, Maximus' testimony)

9. The Appellant does not receive regularly scheduled Physical, Occupational or Psychological therapy. (Exhibit 9, Facility's Testimony)

10. The Appellant's current medications are as follows: Tylenol, Flexeril, Nicotine, Neurontin, Trazodone, Norvac, Wellbutrin, Lisinopril, Toprol, Remeron and Thaimine. (Appellant's Exhibit 1: Progress Note dated [redacted], Facility's testimony)

11. The Facility is currently working with the Money Follows the Person program, the Social Innovation Fund, and the Rental Assistance Program to find alternative placement for the Appellant. (Facility's testimony)

12. The Facility expressed concern that they do not have a location in place for the Appellant to be discharged to, and that he may pose a fall risk outside of the Facility due to his unsteady gait. (Facility's testimony)

13. The Facility has not submitted any further medical documentation to Maximus since the NOA was issued on [redacted], 2022. (Maximus' testimony, Facility's testimony)

14. Neither the Facility nor the Appellant submitted any evidence to support the position that the Appellant requires constant and continuous care for a chronic condition at the nursing home level of care. (Hearing Record, Facility's testimony)

15. The issuance of this decision is timely under Connecticut General Statutes ("Conn. Gen. Stat.") §17b-61(a), which requires that a decision be issued within [redacted] days of the request for an administrative hearing. The Appellant requested an administrative

hearing on [redacted], 2022. The decision is therefore due no later than [redacted], 2023, making this decision timely. (Hearing Record)

CONCLUSIONS OF LAW

1. Conn. Gen. Stat. § 17b-2 provides that the Department of Social Services is designated as the state agency for the administration of (6) the Medicaid program pursuant to Title XIX of the Social Security Act.

   Conn. Gen. Stat. § 17b-261b (a) provides that the Department of Social Services shall be the sole agency to determine eligibility for assistance and services under programs operated and administered by said department.

   Conn. Gen. Stat. § 17b-262 (a) provides that the Commissioner of Social Services may make such regulations as are necessary to administer the medical assistance program. Such regulations shall include provisions requiring the Department of Social Services (1) to monitor admissions to nursing home facilities, as defined in section 19a-521, and (2) to prohibit the admission by such facilities of persons with primary psychiatric diagnoses if such admission would jeopardize federal reimbursements.

   The Department has the authority to administer Medicaid and make regulations regarding nursing home admissions.

2. Regulations of Connecticut State Agencies ("Regs., Conn. State Agencies") § 17b-262-707 (a) provides that 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 before the department authorizes 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 a mental illness or mental retardation as identified by the *preadmission MI/MR screen*.

Regs., Conn. State Agencies §17b-262-707 (b) provides that the Department shall pay a provider only when the department has authorized payment for the client's admission to that nursing facility.

The Appellant is a resident of a skilled nursing facility which requires authorization by the Department for payment.

3. Title 42 of the Code of Federal Regulations ("C.F.R.") § 409.31 (b) provides for specific conditions for meeting the level of care requirements. (1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis. (2) Those services must be furnished for a condition – (i) For which the beneficiary received inpatient hospital or inpatient CAH services, or (ii) Which arose while the beneficiary was receiving care in an SNF or swing-bed hospital for a condition for which he or she received inpatient hospital or inpatient CAH services; or (iii) For which, for an M + C enrollee described in § 409.20(c)(4), a physician has determined that a direct admission to an SNF without an inpatient hospital or inpatient CAH stay would be medically appropriate. (3) The daily skilled services must be ones that, as a practical matter, can only be provided in an SNF, on an inpatient basis.

   The Appellant is a resident of the [redacted] nursing facility and was correctly authorized to receive payment for nursing facility services.

4. 42 C.F.R. § 483.102 provides for the screening or reviewing of all individuals with mental illness or intellectual disability who apply to or reside in Medicaid certified NFs regardless of the source of payment for the NF services, and regardless of the individual's or resident's known diagnoses.

   42 C.F.R. § 483.104 provides as a condition of approval of the State Plan, the State must operate a preadmission screening and annual resident review program that meets the requirements of §§ 483.100 through 438.138.

   42 C.F.R. § 483.112 provides for the preadmission screening of applicants for admission to NFs. (a) *Determination of need for NF services.* For each NF applicant with MI or IID, the State mental health or intellectual disability authority (as appropriate) must determine, in accordance with § 483.130, whether, because of the resident's physical and mental condition, the individual requires the level of services provided by a NF. (b) Determination of need for specialized services. If the individual with mental illness or intellectual disability is determined to require a NF level of care, the State mental health or intellectual disability authority (as appropriate) must also determine, in accordance with § 483.130, whether the individual requires specialized services for the mental illness or intellectual disability, as defined in § 483.120.

   42 C.F.R § 483.128 (a) provides that the State's PASRR program must identify all individuals who are suspected of having MI or IID as defined in §483.102. This

identification function is termed Level I. Level II is the function of evaluating and determining whether NF services and specialized services are needed. The State's performance of the Level I identification function must provide at least, in the case of first-time identifications, for the issuance of written notice to the individual or resident and his or her legal representative that the individual or resident is suspected of having MI or IID and is being referred to the State mental health or intellectual disability authority for Level II screening.

Maximus properly completed a Level 1 evaluation of the Appellant pursuant to federal regulations.

5. 42 C.F.R. § 483.132 (a) provides that for each applicant for admission to a NF and each NF resident who has MI or IID, the evaluator must assess whether: (1) The individual's total needs are such that his or her needs can be met in an appropriate community setting; (2) The individual's total needs are such that they can be met only on an inpatient basis, which may include the option of placement in a home and community-based services waiver program, but for which the inpatient care would be required; (3) If inpatient care is appropriate and desired, the NF is an appropriate institutional setting for meeting those needs in accordance with §483.126; or; (4) If the inpatient care is appropriate and desired but the NF is not the appropriate setting for meeting the individual's needs in accordance with §483.126, another setting such as an ICF/IID (including small, community-based facilities), an IMD providing services to individuals aged 65 or older, or a psychiatric hospital is an appropriate institutional setting for meeting those needs.

   42 C.F.R. § 483.132 (b) provides for Determining appropriate placement. In determining appropriate placement, the evaluator must prioritize the physical and mental needs of the individual being evaluated, considering the severity of each condition.

   42 C.F.R. § 483.132 (c) provides that at a minimum, the data relied on to decide must include: (1) Evaluation of physical status (for example, diagnoses, date of onset, medical history, and prognosis); (2) Evaluation of mental status (for example, diagnoses, date of onset, medical history, likelihood that the individual may be a danger to himself/herself or others); and (3) Functional assessment (activities of daily living)

   Maximus' review of the Appellant's condition determined that he is independent with all his ADL's. Maximus further found that the Appellant is not a danger to himself or others and that his needs could be met in a less restrictive setting.

6. 42 C.F.R. § 440.230 provides for sufficiency of amount, duration, and scope. (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or utilization control procedures.

Conn. Gen. Stat. § 17b-259b provides the following: (a) 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 (b) provides that 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.

The Appellant does not have uncontrolled and/or unstable or medical conditions that require daily skilled nursing services.

The Appellant does not have any chronic medical conditions that require substantial assistance with personal care and is physically able to complete his ADL's.

Maximus correctly determined that it is not clinically appropriate for the Appellant to reside in a nursing facility.

Maximus correctly determined that Appellant does not meet the medically necessary criteria for nursing facility level of care. His medical needs could be met with services available in the community.

7. Conn. Gen. Stat. § 17b-259b(c) provides for *Notice of Denial of Services*. 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.

Maximus correctly issued a NOA on [redacted], 2022, denying nursing facility level of care. The NOA correctly contained a level of care explanation which outlined the criteria and reason for the denial.

DECISION

The Appellant's appeal is **DENIED.**

Joseph Davey
Administrative Hearing Officer

CC: hearings.commops@ct.gov
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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 §4-1181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, 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 06105-3725.

RIGHT TO APPEAL

The appellant has the right to appeal this decision to Superior Court with (**45**) days of the mailing of this decision, or (**45**) days after the agency denies 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 fooled 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 06105-3725. 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 her 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.