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

[redacted] **2023**
SIGNATURE CONFIRMATION

CASE # [redacted]
CLIENT ID # [redacted]
REQUEST # [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2022, Maximus Management Innovations LLC ("Maximus"), the Department of Social Services (the "Department") contractor that administers approval of nursing home care, sent [redacted] (the "Appellant") a Notice of Action ("NOA") denying nursing facility level of care ("NFLOC") as not being medically necessary.

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

On [redacted] 2023, the Office of Legal Counsel, Regulations, and Administrative Hearings (the "OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2023, to be held in-person at the facility.

On [redacted] 2023, the Appellant requested the hearing be rescheduled as her son/Conservator was unable to attend that day.

On [redacted], 2023, the OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2023, to be conducted via telephonic conferencing.

On [redacted] 2023, the administrative hearing was held via telephonic conferencing and the following individuals participated:

[redacted], Appellant
[redacted], Appellant's Son/Conservator
[redacted], Facility Social Worker
Erin Scafe, Registered Nurse, DSS
Jean Denton, Licensed Practical Nurse Supervisor, Ascend Representative
Joseph Alexander, Administrative Hearing Officer, DSS OLCRAH

STATEMENT OF THE ISSUE

The issue to be decided is whether Maximus' decision to deny the NFLOC for the Appellant as not being medically necessary was correct.

FINDINGS OF FACT

1. The Appellant is [redacted] ([redacted]) years old (DOB [redacted]) and a recipient of Husky C Medicaid program. (Ex. 6: Level of Care Determination)

2. On [redacted] 2022, the Appellant was admitted to [redacted] with a diagnosis of sepsis, PNA (Pneumonia), acute drug intoxication, and metabolic encephalopathy. (Hearing Record)

3. On [redacted] 2022, [redacted] submitted a Nursing Facility Level of Care ("NFLOC") screening form to Maximus describing the Appellant's Activities of Daily Living ("ADL") support needs as requiring hands on assistance with bathing, toileting, mobility, and transfers, and supervision with dressing, eating and continence. The Appellant's Instrumental Activities of Daily Living ("IADL") were described as requiring verbal assistance with medications, and continual supervision with meal preparation. Based on this information the Appellant required a Level 1 screen and received a short-term approval of NFLOC totaling [redacted] ([redacted]) days. The approval was scheduled to expire on [redacted], 2022. (Hearing Record)

4. On [redacted], 2022, the Appellant was admitted to [redacted] (the "Facility"). with the following diagnosis: Sepsis due to PNA, Hx polysubstance drug use, Alzheimer's D/O, asthma, acute hypoxia, hypercapnia, HTN depression, heroin and cocaine use, memory loss, migraine D/O, psychiatric illness, lactic acidosis, PNA, encephalopathy, MI (Myocardial Infarction), DVT (Deep Vein Thrombosis). (Ex 6: Level of Care Determination, Hearing Record)

5. On [redacted], 2022, the Facility submitted a NFLOC screening form to Maximus for review. The NFLOC described the Appellant's ADL support needs as requiring hands on assistance with bathing, and supervision with dressing, eating, toileting, mobility, and transfer. The Appellant's IADLs were described as requiring physical assistance with medications and total assistance with meal preparation. Based on this information the Appellant required a medical review. (Ex 4: ADL Measures and Ratings)

6. On [redacted], 2022, the Completed Care Details and minimum data set were reviewed. Per the Completed Care Details the Appellant is independent with "set up" help with all her ADLs. Per the minimum data set (dated [redacted]) the Appellant received a score of 15/15 on a Brief Interview for Mental Status ("BIMS"). Based on this review it was determined a Medical Doctor needed to conduct a review of various documents to establish the Appellant's proper level of care needs. (Ex 8: Completed Care Details, Ex. 13: Minimum Data Set, Hearing Record)

7. On [redacted] 2022, a Medical Doctor review was conducted using all available information related to the Appellant's medical and total needs. The review concluded nursing facility level of care was not medically necessary for the Appellant because she did not require the continuous nursing services delivered at the level of the nursing facility and her needs could be met in the community in a less restrictive setting with appropriate supports. (Ex. 7: Practitioner's Certification, Ex. 8: Completed Care Details, Ex. 9: Physician Orders, Ex. 10: Harvest Provider's Note, Ex. 11: Progress Notes, Ex. 12: Nurses Notes, Ex. 13: Minimum Data Set, Ex. 14: Occupational Therapy Note, Ex. 15: Physical Therapy Note, Ex. 16: Interdisciplinary Rehabilitation Screening)

8. On [redacted], 2022, a NOA was sent to the Appellant informing her that she did not meet the nursing facility level of care criteria. (Ex. 5: Notice of Action)

9. On [redacted], 2022, OLCRAH received the Appellant's hearing request form. (Dept. Ex. 2: Hearing Request)

10. The Appellant would pose a significant risk to her own health and safety should she be released from the supervised setting of a facility at this time. (Facility Testimony)

11. 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, making this decision due by [redacted], 2023. However, due to the rescheduling of this hearing, an additional [redacted] days have been added making this decision due no later than [redacted], 2022, since [redacted], 2022, is a Saturday.

CONCLUSIONS OF LAW

1. Conn. Gen. Stat. § 17b-2 provides 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 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 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 under state statute to administer the HUSKY-C Medicaid program and make regulations for the same.

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 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 long-term care facility authorized to receive payment for nursing home services.

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 has previously met the NFLOC criteria before the issuance of the [redacted], 2022, notice of action denying such approval.

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.

   Maximus properly completed a Level 1 evaluation of the Appellant per Federal regulations.

5. Conn. Gen. Stats. § 17b-295b provides for the definition of “medically necessary” and “medical necessity” as follows: (a) For purposed 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 maintain the individual’s achievable health and independent functioning as provided such services are: (1) Consistent with generally acceptable 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 (b) 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. (c) 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 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 used clinical criteria and guidelines solely as screening tools.

Maximus correctly determined the Appellant does not have a chronic medical condition requiring substantial assistance with personal care based on the NFLOC screening form submitted for review.

Maximus correctly determined the Appellant does not have uncontrolled and/or unstable medical or mental health conditions requiring continuous skilled nursing services and/or nursing supervision based on the NFLOC screening form submitted for review.

Maximus correctly determined that it is not clinically appropriate for the Appellant to reside in a nursing facility based on the NFLOC screening form submitted for review.

Maximus correctly determined that nursing facility services are not medically necessary for the Appellant because her needs could be met with services offered in the community based on the NFLOC screening form submitted for review.

DISCUSSION

During the hearing, the Appellant's Conservator expressed his concern that the Appellant would not make herself available for nursing services, or any other community-based supports and would not independently monitor/administer her own medications. The Facility Social Worker testified the Appellant is unable to independently manage her medications thus she requires support and supervision from another party.

The Department's Registered Nurse testified the Appellant would face significant challenges if residing in the community due to her diagnosis of Alzheimer's disease with unpredictable and progressive mental impairment in addition to her poly substance abuse and psychosocial issues. It is the Registered Nurses opinion the Appellant requires supervision to allow her to perform her ADLs and IADLs and to maintain her functional status, medication regiment and insights and judgement concerning her care.

The Maximus representative testified the decision to deny NFLOC was based solely on the NFLOC screening form submitted to them. While the diagnosis of Alzheimer's disease was taken into consideration, the Appellant does not appear to need NFLOC as the progress notes indicate she is able to perform her ADLs and IADLs independently in addition to her scoring 15/15 on the BIMS.

The undersigned Hearing Officer finds it would be in the best interest of the Appellant to have a phycological evaluation completed and the results submitted to Maximus via a new NFLOC screening form.

DECISION

The Appellant's appeal is **REMANDED** to the Facility for further action.

ORDER

The Facility shall submit to Maximus for review, all documentation, including a psychological evaluation and/or neuro-cognitive tests, supporting the testimony provided during the hearing that the Appellant needs to remain under the care of a supervised nursing facility setting due to her Alzheimer's diagnosis.

The Facility shall provide the undersigned hearing officer with confirmation such documentation has been sent to Maximus for review by no later than [redacted], 2023.

Joseph Alexander

Joseph Alexander
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, 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 06105-3725.

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.