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

[redacted]
[redacted]
Request # 208962

NOTICE OF DECISION

PARTY

[redacted]
[redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2022, Maximus, the Department of Social Service's (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") indicating that he does not meet the NFLOC criteria.

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

On [redacted] 2023, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling an administrative hearing for [redacted] 2023.

On [redacted] 2023, in accordance with sections 17b-60, 17-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing. The following individuals participated in the hearing:

[redacted] Appellant
[redacted], Social Worker, [redacted]
[redacted], Interpreter, [redacted] via telephone

Paul Cook, Maximus Representative via telephone
Patricia Jackowski, RN., Community Nurse Coordinator, Community Options, Department's Representative
Carla Hardy, Hearing Officer

This hearing decision will be translated to [redacted] and mailed at a later date.

STATEMENT OF THE ISSUE

The issue to be decided is whether Maximus' decision that the Appellant does not meet the criteria for NFLOC is correct.

FINDINGS OF FACT

1. The Appellant is 64 years old (DOB [redacted]/58). (Exhibit 5: Level of Care Determination)

2. On [redacted] 2022, the Appellant was admitted to [redacted] with a diagnosis of bilateral lower leg pain secondary to peripheral polyneuropathy. (Hearing Record)

3. The Appellant had pain and could not feel his legs. He had difficulty ambulating. (Social Worker's Testimony)

4. On [redacted] 2022, the Appellant received an exempted hospital discharge. (Hearing Record)

5. On [redacted] 2022, the Appellant was admitted to [redacted] a skilled nursing facility. His nursing approval expired on [redacted] 2022. (Hearing Record)

6. On [redacted], [redacted] submitted a Nursing Facility Level of Care ("NFLOC") screening form to Maximus. The screening described the Appellant as requiring the following supports with his Activities of Daily Living ("ADLs"): hands on assistance with bathing, dressing, toileting, mobility, transfer, and continence and supervision for eating. The Appellant required assistance with the following Instrumental Activities of Daily Living ("IADLs"): verbal and physical assistance with medications and total assistance with meal preparation. Based on this information, the Appellant required a Level 1 Screen. He received a 120-day short-term approval which expired on [redacted] 2022. (Hearing Record)

7. The ADL Measures include bathing, dressing, eating, toileting, continence, transferring and mobility. (Exhibit 3: ADL Measures and Ratings)

8. On [redacted] 2022, the nursing facility submitted an NFLOC screening form to Maximus. The screening described the Appellant as requiring the following supports with his ADLs: hands on assistance with bathing and supervision with dressing, eating, and continence. The Appellant required assistance with the following IADLs: verbal and physical assistance with medications and total assistance with meal preparation. The Appellant required a Medical Doctor Review based on the information provided. (Hearing Record)

9. The plan of care ("POC") response history indicates the Appellant is independent with all ADLs. (Exhibit 7: POC Response History, [redacted]/22; Hearing Record)

10. Maximus reviewed the Appellant's NFLOC screen, Practitioner Certification, Minimum Data Set, Progress Notes, POC Response Report, Occupational Therapy Notes, Order Summary Report, and Physical Therapy Note. Maximus concluded that nursing facility level of care is not medically necessary for the Appellant because he does not require the continuous nursing services delivered at the level of the nursing facility. It was determined that his needs could be met in the community with appropriate supports.(Hearing Record)

11. The Appellant is not receiving physical, occupational, speech, or respiratory therapy. (Appellant's Testimony)

12. The Appellant uses a rollator to ambulate. (Appellant's Testimony)

13. The Appellant receives medication setups that all patients at the nursing facility receive. (Social Worker's Testimony)

14. The Appellant requires supervision while bathing because he is weak. He is independent with his other ADLs. (Appellant's Testimony)

15. The Appellant's BIMS score was 13 in [redacted] 2022 and 11 in [redacted]2023. (Social Worker's Testimony)

16. BIMS is a cognitive assessment. (Social Worker's Testimony)

17. The Appellant has not placed an application with the Department's Money Follows the Person ("MFP") program. (Social Worker's Testimony)

18. On [redacted] 2022, Maximus issued an NOA to the Appellant indicating that he does not meet the medical criteria for NFLOC because his needs can be met through a combination of medical, psychiatric, and social services delivered outside of the nursing facility. As a result, he is not eligible for Medicaid coverage of nursing facility services. (Exhibit 4: NOA, [redacted]22)

19. 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 no later than [redacted], 2023.

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes ("Conn. Gen. Stats.") authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.

2. State regulations provide 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 ("Regs., Conn. State Agencies") Section. 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." [Regs., Conn. State Agencies Section 17b-262-707(a)].

3. Regs., Conn. State Agencies § 19-13-D8t(d)(1)(A) provides that "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 personal care, on a daily basis."

4. Title 42 of the Code of Federal Regulations ("C.F.R.") Section 409.31(b) provides for specific conditions for meeting 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 impatient hospital or inpatient CAH services; or (ii) Which arose while the beneficiary was receiving care in a 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 a 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 a SNF, on an inpatient basis.

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

5. Title 42 C.F.R. § 483.132 provides for evaluating the need for NF (nursing facility) services and NF level of care (PASARR/NF)

   Title 42 C.F.R. § 483.132(b) provides in determining appropriate placement the evaluator must prioritize the physical and mental needs of the individual being evaluated, taking into account the severity of each condition.

   Title 42 C.F.R.§ 483.132(c) provides 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 properly completed an evaluation and assessment of the Appellant following Federal Regulations.

6. Conn. Gen. Stats. § 17b-259b provides the definition of "Medically necessary" and "medical necessity". (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. (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 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.

7. Title 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.

Maximus correctly determined that the Appellant does not require substantial assistance with his ADLs.

Maximus correctly determined that the Appellant does not have a chronic medical condition requiring substantial assistance with personal care.

Maximus correctly determined that the Appellant does not have uncontrolled and/or unstable medical conditions requiring continuous skilled nursing services and/or nursing supervision.

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

Maximus correctly determined that nursing facility services are not medically necessary for the Appellant, because his medical needs can be met with services offered in the community.

On [redacted] 2022, Maximus correctly denied the Appellant's request for approval of long-term care Medicaid.

DECISION

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

Carla Hardy
Carla Hardy
Hearing Officer

Pc: Department of Social Services, Community Options
Maximus

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.