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

[redacted]
Signature Confirmation

Case #: [redacted]
Client #: [redacted]
Request #: 211171

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 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") saying that she does not meet the nursing facility level of care criteria.

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

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

On [redacted], 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 were present at the hearing:

[redacted], Appellant
[redacted]
Jean Denton, Maximus Representative
Erin Scafe, R.N. Community Options, Central Office, Hartford
Shawn P. Hardy, Hearing Officer

STATEMENT OF THE ISSUE

The issue is whether Maximus correctly denied the Appellant's NFLOC request for nursing home services as not medically necessary.

FINDINGS OF FACT

1. On [redacted], the Appellant was admitted to [redacted] with the diagnoses of [redacted], [redacted], and [redacted]. The Appellant required no hands-on assistance with Activities of Daily Living. ("ADL") For Instrumental Activities of Daily Living ("IADL"), the Appellant required assistance with injections and set up assistance with medications, and no assistance with meal preparation. (Hearing Summary)

2. The Appellant is [redacted] ([redacted]), was homeless prior to admission to [redacted] (the "hospital"), and to the Facility. (Exhibit 2: Level of Care Form)

3. The Appellant does not have a Conservator/Legal Guardian. (Appellant's Testimony)

4. On [redacted], Maximus granted a 60-day short term approval for NFLOC, which expired on [redacted]. (Hearing Summary)

5. The Appellant received Occupational Therapy from [redacted], through [redacted]. (Exhibit 9: Occupational Therapy Discharge Summary [redacted])

6. The Appellant was diagnosed with [redacted]. (Exhibit 8: Psychiatric Evaluation & Consultation Form [redacted])

7. On [redacted], the Facility submitted the Nursing Facility Level of Care (NFLOC) screening form to Maximus requesting NFLOC approval. The NFLOC screen described the Appellant's current ADL support needs as follows: The Appellant required supervision with bathing, dressing, eating, mobility, toileting, continence, and transfer. For IADLs, the Appellant required verbal assistance with medications and minimal assistance with meal prep. Per the Point of care History which charts a resident's care needs, the Appellant is independent with all of her ADLs with intermittent setup assistance. (Hearing Summary)

8. After review of the NFLOC screen, Practitioner Certification, Trident Care Imaging, Progress Notes, Point of Care History, Psychiatric Evaluation and Consultation, Occupational Therapy Notes, Maximus's medical doctor concluded that NFLOC is not medically necessary for the Appellant because she does not require the

continuous nursing services delivered at the level of the nursing facility. Her needs could be met in less restrictive setting. Per the Resident Care ADL Assistance & Support, the Appellant is independent with all ADL's.-Maximus denied the Facility's request for short term approval for NFLOC. (Hearing Summary, Exhibit 1: Notice of Action, [redacted])

9. The Appellant currently takes multiple medications at multiple times during the day. (Exhibit 6: Administration Notes, [redacted])

10. The Appellant requires cueing for medication. (Social Worker's Testimony, Exhibit 2: Maximus Connecticut Level of Care Form, [redacted])

11. Intravenous treatment for right shoulder infection ended [redacted]. (Exhibit 5: Progress Notes, [redacted])

12. The Appellant is fully oriented and needs no prompting or cueing for Self, Place, Time, Situation, and Memory. The Appellant solves problems and makes decisions with no assistance. The Appellant communicates information intelligibly and understands information conveyed without assistance. (Exhibit 2)

13. The Appellant has an active referral with [redacted] to help her transition back into the community. (Hearing Record)

14. Although the Appellant is diagnosed with [redacted], a treatment plan was not listed. (Exhibit 2)

15. The Appellant attends [redacted] and [redacted] meetings. (Appellant's Testimony)

16. The Appellant is capable of bathing, dressing, toileting, mobilizing, eating, and transferring independently. (Appellant's Testimony)

17. The Appellant says she needs a knee replacement, unfair that she may have to leave the SNF. (Appellant's Testimony)

18. The Appellant uses a walker due to mobility issues. (Exhibit 4: Point of Care History, [redacted])

19. On [redacted], Maximus issued a Notice of Action (NOA) to the Appellant indicating that she does not require continuous nursing services delivered at the level of the NF. Her needs can be met in a less restrictive setting. The NOA states, "The Appellant would need intermittent assistance through home health, visiting nurse of some other venue to monitor her condition. (Exhibit 1: Notice of Action, [redacted].)

20. The issuance of this decision is timely under Connecticut General Statutes Section 17b-61(a), which requires that the agency issue a decision within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted]; therefore, this decision is due no later than [redacted]

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes 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. 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." Regulations of Connecticut State Agencies (Regs., Conn. State Agencies) § 17b-262-707 (a).

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).

The Appellant is a resident of a long-term care facility authorized to receive payment for NF services.

4. State regulations provide that Patients shall be admitted to the facility only after a physician certifies the following:

a. 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."

(i) That a patient admitted to a rest home with nursing supervision has controlled and/or stable chronic conditions which require minimal skilled nursing services, nursing supervision, or assistance with personal care on a daily basis. Conn. Agencies Regs. § 19-13-D8t(d)(1)(A).

5. Section 17b-259b of the Connecticut General Statutes states that "Medically necessary" and "medical necessity" defined. Notice of denial of services. Regulations.

(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.

Maximus correctly determined that the Appellant does not have uncontrolled and/or unstable conditions requiring nursing services because the Appellant is independent with all her ADL's and her needs could be met through a combination of social and professional services outside a nursing facility setting.

Maximus correctly determined that the Appellant's medical conditions do not require NFLOC and can be addressed in a less restrictive setting.

Maximus correctly denied the Appellant's NFLOC request for nursing home services as not medically necessary because the Appellant does not meet the medical criteria as established under state statutes and state regulations.

DECISION

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

Shawn P. Hardy
Shawn P. Hardy
Hearing Officer

Pc: hearings.commops@ct.gov
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.