

Cynthia Scott, State Long-Term Care Ombudsman
Stacy Bent, RN, 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], 2023, the Appellant fell and injured her ankle. She was admitted to [REDACTED] for evaluation of the injury. (Exhibit 13: [REDACTED] Discharge Report, Appellant's testimony)
4. On [REDACTED], 2023, the Appellant was discharged from [REDACTED] and was admitted to the Facility with the following diagnosis: chronic pain. (Hearing Record, Maximus' testimony)
5. On [REDACTED], 2023, the Facility submitted a NFLOC screening form to Maximus for review. The NFLOC form described the Appellant's Activities of Daily Living ("ADL's") as requiring hands-on assistance with bathing, dressing, and mobility. The Appellant's Instrumental Activities of Daily Living ("IADL's") were described as requiring minimal assistance with meal preparation. After reviewing the NFLOC form, Maximus approved the Appellant for a 120-day short-term approval. The approval expired on [REDACTED], 2023. (Hearing Record, Maximus' testimony)
6. On [REDACTED], 2023, the Appellant received an MRI on her left ankle at [REDACTED]. The MRI revealed the following: "Complete tear of the Achilles tendon. Incomplete visualization of anterior talofibular ligament, suggesting at least high-graded if not complete tear. Sprain/partial tear of posterior tibial fibular ligament. High-grade tear of deltoid ligament. Partial tearing of peroneus longus and brevis tendons." The information from the MRI was not submitted to Maximus for evaluation. (Exhibit 11: Diagnostic Imaging results [REDACTED], Facility's testimony, Maximus' testimony)
7. The Appellant received Physical Therapy upon her admittance to the Facility. She does not receive regularly scheduled Occupational or Psychological therapy. (Appellant's testimony, Facility's testimony)

8. On [REDACTED], 2023, the Appellant's Physical therapy ended. On that date, the Facility determined the Appellant's improvement was sufficient to declare the Physical Therapy successful and no longer needed. (Facility's testimony)
9. On [REDACTED], 2023, the Facility submitted a second NFLOC screening form to Maximus. The NFLOC form described the Appellant's ADL's as requiring no assistance with bathing, dressing, eating, toileting, transfer, mobility and continence. The Appellant's IADL's were described as requiring no assistance with medications or meal preparations. After review, Maximus determined that a medical doctor review was needed. During the review it was noted the Appellant's needs could be met in the community with appropriate supports. (Hearing Record)
10. On [REDACTED], 2023, Dr. William Regan MD, the medical doctor for Maximus, assessed the Appellant's medical condition using the following: NFLOC screen, Practitioner Certification, Point of Care History, Progress Notes, and Face Sheet. 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 her 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 7: Practitioner Certification dated [REDACTED], Exhibit 8: Point of Care History dated [REDACTED], Exhibit 9: Progress Note dated [REDACTED], Exhibit 10: Face Sheet dated [REDACTED], Hearing Record)
11. On [REDACTED], 2023, Maximus issued a NOA to the Appellant informing her that she did not meet the criteria necessary for nursing facility level of care. (Exhibit 5: Notice of Action dated [REDACTED])
12. On [REDACTED], 2023, the OLCRAH received the Appellant's hearing request form. (Exhibit 1: Notice of Administrative Hearing dated [REDACTED], Exhibit 2: Hearing Request dated [REDACTED])
13. The Appellant has some difficulty with bathing, dressing and mobility but is otherwise independent with her ADL's and IADL's. (Appellant's testimony, Facility's testimony, Hearing Record)
14. The Appellant's current medications are as follows: Acetaminophen, Albuterol, Baclofen, Dulcolax, Famotidine, Sodium Phosphate, Levothyroxine, Lidocaine, Milk of Magnesia and Pantoprazole. (Exhibit 12: Medication list)
15. The Facility is working with the [REDACTED] (" [REDACTED] ") and [REDACTED] [REDACTED] (" [REDACTED] ") programs to find alternative placement for the Appellant. (Facility's testimony)
16. The Appellant has no community home or apartment and is unable to return to live with her son. (Appellant's testimony)

17. At the time of the hearing, the Facility had not submitted any further medical documentation to Maximus since the NOA was issued on [REDACTED], 2023. (Maximus' testimony, Facility's testimony)
18. 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], 2023. The decision is, therefore, due no later than [REDACTED], 2023. (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 she is independent with all her ADL's. Maximus further found that the Appellant is not a danger to herself or others and that her 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.

Maximus correctly determined the Appellant does not have uncontrolled and/or unstable or medical conditions that require daily skilled nursing services based on the most recent NFLOC screening form provided.

Maximus correctly determined the Appellant does not have any chronic medical conditions that require substantial assistance with personal care and is physically able to complete her ADL's based on the most recent NFLOC screening form provided.

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

Maximus correctly determined that the Appellant does not meet the medically necessary criteria for nursing facility level of care. Her medical needs could be met with services available in the community based on the most recent NFLOC screening form provided.

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.

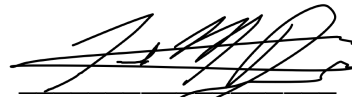
Maximus correctly issued a NOA on [REDACTED], 2023, denying nursing facility level of care. The NOA correctly contained a level of care explanation which outlined the criteria and reason for the denial.

DISCUSSION

During the hearing, the Appellant testified that her initial fall on [REDACTED], 2023, resulted in a tear in her Achilles tendon that went undiagnosed until [REDACTED], 2023, when she received an MRI on her ankle at [REDACTED]. The information on her Achilles tear has not been submitted to Maximus for evaluation. However, the Appellant testified that although she has difficulty with mobility, bathing, and dressing, she does not require any outside assistance to accomplish these activities. Based on the evidence and testimony submitted, the undersigned finds that the Appellant is independent with her ADL's and therefore Maximus' decision to deny nursing facility level of care was correct.

DECISION

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

A handwritten signature in black ink, appearing to read 'J. Davey', written over a horizontal line.

Joseph Davey
Administrative Hearing Officer

CC: hearings.commops@ct.gov
AscendCTadmihearings@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 §4-1181a (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 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 06105-3725. 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.

