STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3730

[redacted]
SIGNATURE CONFIRMATION

CASE ID # [redacted]
CLIENT ID # [redacted]
REQUEST # 233894

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

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

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

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

On [redacted], in accordance with sections 17b-60, 17-61, and 4-176e to 4-184 inclusive, of the Connecticut General Statutes, the OLCRAH held an in-person administrative hearing.

The following individuals participated in the hearing:

[redacted], Appellant
[redacted], [redacted] Social Worker
Mary Perrotti, Registered Nurse, Community Options, Department of Social Services
Robert Mosteller, Maximus, via telephone
Sara Hart, Hearing Officer

STATEMENT OF THE ISSUE

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

FINDINGS OF FACT

1. The Appellant is age [redacted] (DOB: 1[redacted]) and a Medicaid recipient of long-term care support services. *(Exhibit 6: Level of Care Form, Hearing Record)*

2. On [redacted], [redacted] admitted the Appellant with a diagnosis of chest pressure, mild DKA, and transient sinus tachycardia. *(Hearing Summary)*

3. On [redacted], [redacted] submitted a Pre-Admission Screening Resident Review ("PASSR") form to Maximus. Based on the provided information, Maximus approved for a 30-day exempted hospital discharge through [redacted] for the Appellant. *(Hearing Summary)*

4. On [redacted] [redacted] ("[redacted]"), a skilled nursing facility, admitted the Appellant. *(Hearing Summary, Mosteller Testimony)*

5. On [redacted], [redacted] submitted a NFLOC screening form referral to Maximus requesting approval for a continued stay at WCC. The NFLOC form described the individual's current Activities of Daily Living ("ADLs") support needs as follows: the Appellant required hands-on assistance with bathing and toileting and supervision with dressing, mobility, and transfer. For Instrumental Activities of Daily Living ("IADLs"), the Appellant required minimal support with meal preparation and injection support with medications. *(Hearing Summary)*

6. On [redacted], [redacted] submitted a PASSR screening form to Maximus. Based on the information provided, Maximus completed a medical doctor review and determined that the Appellant's needs could be met in the community with appropriate supports. *(Hearing Summary)*

7. On [redacted], [redacted] submitted another NFLOC referral to Maximus. The NFLOC screen described the individual's current ADL support needs as follows: the Appellant required total dependence with continence, toileting, dressing, bathing, hands-on assistance with mobility and transfers, and supervision with eating. For IADLs, the Appellant required total assistance with meal preparation and medication support with injections. Based on this information, Maximus recommended a Medical Onsite evaluation. *(Hearing Summary)*

8. On [redacted], Maximus conducted a medical on-site review and determined the Appellant's needs could be met in the community with appropriate supports. *(Mosteller Testimony, Hearing Summary)*

9. On [redacted], Dr. Judy Regan from Maximus completed an evaluation of the Appellant and his medical condition and determined that NFLOC is not medically necessary for the Appellant and that his needs could be met in a less restrictive setting. *(Hearing Summary)*

10. On [redacted], Maximus issued a notice of action to the Appellant and Facility indicating that NFLOC placement is not medically necessary for the Appellant. *(Exhibit 5: NOA [redacted])*

11. On [redacted], the Department received the Appellant's hearing request. *(Hearing Record)*

12. [redacted]'s Completed Care Details for the period of [redacted], through [redacted] reflect that the Appellant is independent with his ADLs and did not require continuous hands-on assistance with bathing, dressing, eating, toileting, continence, transferring, or mobility. *(Exhibit 9: Completed Care Details [redacted], Exhibit A: Completed Care Details [redacted])*

13. The Appellant asserts that he is unable to bathe himself without assistance, is incapable of preparing his own meals, and requires assistance with medication administration. *(Appellant's Testimony)*

14. The Appellant uses a walker to assist with locomotion. *(Appellant's Testimony)*

15. The Appellant is not currently receiving speech, occupational, or physical therapy services. *(Hearing Record, Appellant's Testimony)*

16. Neither the Facility nor the Appellant submitted evidence to support the position that the Appellant needs constant and continuous care for a chronic condition equal to that of a nursing home level. *(Hearing Record)*

17. The issuance of this decision is timely under Connecticut General Statutes ("Conn. Gen. Stat.") 17b-61(a), which requires that the OLCRAH issue a decision within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted], with this decision due no later than [redacted].

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.

2. Section 17b-262-707(a) of Regulations of Connecticut State Agencies 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*.

    Section 17b-262-707(b) of the Regulations of Connecticut State Agencies 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, and upon admission, was authorized to receive payment for NF services.

3. 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 inpatient 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.

    At the time of his admission to the Facility, the Appellant met the NFLOC criteria.

4. Conn. Gen. Stat. § 17b-259b(a) provides 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 determining medical necessity.

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 the Appellant does not have uncontrolled and/or unstable conditions requiring continuous skilled nursing services.

Maximus correctly determined that NF services are not clinically appropriate in terms of the level of service or considered effective for the Appellant's illness, injury, or disease. Maximus correctly determined that NF services are not medically necessary for the Appellant because he does not need substantial assistance with personal care on a daily basis.

5. Conn. Gen. Stat. § 17b-259b(c) provides 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 determining medical necessity.

Maximus correctly determined that the Appellant did not meet the medically necessary criteria for a NFLOC based on the information provided on the [redacted] NFLOC submission, and correctly issued a NOA denying NFLOC on [redacted]

DECISION

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

Sara Hart
Hearing Officer

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jeandenton@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, law, and 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 requested 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 the 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 the 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 if 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 to 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 following §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.