STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-16627 CHC
Case No. [redacted]
Load No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] and [redacted] Appellant's parents, appeared on behalf of the Appellant. [redacted], and Appellant's case manager, appeared as a witness for Appellant. [redacted], represented the Department. [redacted], appeared as a witness on behalf of the Department.

ISSUE

Did the Department establish that Appellant no longer met the eligibility criteria for private duty nursing (PDN) services?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a [redacted] year-old Medicaid beneficiary who was born prematurely at [redacted] weeks and diagnosed with chronic lung disease, vocal cord stenosis, and reflux; and he is tracheotomy dependent. (Exhibit 1)

2. The Appellant resides with his mother and father who were employed at the time relevant to this matter.

3. Appellant had been approved for 180 hours of Medicaid-covered PDN Respite.

4. In [redacted] the Department received a request for 6 hours of PDN per day on Appellant's behalf. (Exhibit 1, p. 11)

5. After reviewing Appellant's medical documentation, on [redacted], the Department sent Appellant's legal guardians notice that Appellant was not eligible for PDN services on the basis that: "Submitted documentation does not meet the skilled nursing needs criteria of the Private Duty Nursing benefits." (Exhibit 1, p. 5)

6. On [redacted] and [redacted] the State Office of Administrative Hearings and Rules (SOAHR) received requests for a hearing, filed on Appellant's behalf, protesting the denial of PDN services.

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

The Children's Special Health Care Services program is established pursuant to 42 USC 700, *et seq*. It is administered in accordance with MCL 333.5805, *et seq*.

> Children's Special Health Care Services (CSHCS) is a program within the Michigan Department of Community Health (MDCH) created to find, diagnose, and treat children in Michigan who have chronic illnesses or disabling conditions. Title V of the Social Security Act, Michigan Public Act 368 of 1978, and the annual MDCH Appropriations Act mandate CSHCS. CSHCS promotes the development of service structures that offer specialty health care for the CSHCS qualifying condition that is family centered, community based, coordinated, and culturally competent.
>
> MDCH covers medically necessary services related to the CSHCS qualifying condition for individuals who are enrolled in the CSHCS Program. Medical eligibility must be

> established by MDCH before the individual is eligible to apply for CSHCS coverage. Based on medical information submitted by providers, a medically eligible individual is provided an application for determination of non-medical program criteria.
>
> An individual may be eligible for CSHCS and eligible for other medical programs such as Medicaid, Adult Benefit Waiver I (ABW I), Medicare, or MIChild. To be determined dually eligible, the individual must meet the eligibility criteria for CSHCS and for the other applicable program(s).
>
> *Medicaid Provider Manual, Children's Special Health Care Services, Section 1, April 1, 2009*

General information regarding Private Duty Nursing (PDN) may be found in the Department's Medicaid Provider Manual, Private Duty Nursing, Section 1.

> This chapter applies to Independent & Agency Private Duty Nurses (Provider Types 10, 15). Private duty nursing (PDN) is a Medicaid benefit when provided in accordance with the policies and procedures outlined in this manual. Providers must adhere to all applicable coverage limitations, policies and procedures set forth. PDN is covered for beneficiaries under age 21 who meet the medical criteria in this section. If the beneficiary is enrolled in or receiving case management services from one of the following programs, that program authorizes the PDN services.
>
> - Children's Special Health Care Services (CSHCS)
> - Home and Community-Based Services Waiver for the Elderly and Disabled (known as the MI Choice Waiver) Children's Waiver (Community Mental Health Service Program [CMHSP])
> - Habilitation Supports Waiver (CMHSP)
>
> For a Medicaid beneficiary who is not receiving services from one of the above programs, the CSHCS Program reviews the request for authorization and authorizes the services if the medical criteria and general eligibility requirements are met.
>
> Beneficiaries who are receiving PDN services through one Medicaid program cannot seek supplemental PDN hours

> from another Medicaid Program (i.e., CSHCS, MI Choice Waiver, Children's Waiver, Habilitation Supports Waiver).
>
> For beneficiaries 21 and older, PDN is a waiver service that may be covered for qualifying individuals enrolled in the MI Choice Waiver or Habilitation Supports Waiver. When PDN is provided as a waiver service, the waiver agent must be billed for the services.
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> *Medicaid Provider Manual, Private Duty Nursing, Section 1, April 1, 2009*

The Medicaid covered PDN service limitations are provided in the Medicaid Provider Manual, Private Duty Nursing, Section 1.6.

> The purpose of the PDN benefit is to assist the beneficiary with medical care, enabling the beneficiary to remain in their home.
>
> The benefit is not intended to supplant the care giving responsibility of parents, guardians, or other responsible parties (e.g., foster parents). There must be a primary caregiver (i.e., parent, guardian, significant other adult) who resides with a beneficiary under the age of 18 and the caregiver must provide a monthly average of a minimum of eight hours of care during a typical 24-hour period. The calculation of the number of hours authorized per month includes eight hours of care that will be provided by the caregiver during a 24-hour period, which are then averaged across the hours authorized for the month. The caregiver has the flexibility to use the monthly authorized hours as needed during the month.
>
> The time a beneficiary is under the supervision of another entity or individual (e.g., in school, in day/child care, in work program) cannot be used to meet the eight hours of obligated care as discussed above, nor can the eight hours of care requirement for beneficiaries under age 18 be met by other public funded programs (e.g., MDCH Home Help Program), or other resources for hourly care (e.g., private health insurance, trusts, bequests, private pay).
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> *Medicaid Provider Manual, Private Duty Nursing, Section 1.6, April 1, 2009.*

The medical criteria for PDN services are provided in the Medicaid Provider Manual, Private Duty Nursing in Section 2.2.

To qualify for PDN, the beneficiary must meet the medical criteria of **either** I and III below **or** II and III below**:**

Medical Criteria I – The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

- Mechanical ventilation four or more hours per day or assisted respiration (Bi-PAP or CPAP); or
- Oral or tracheostomy suctioning eight or more times in a 24-hour period; or
- Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
- Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
- Continuous oxygen administration, in combination with a pulse oximeter and a documented need for observations and adjustments in the rate of oxygen administration.

Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments or interventions (as described in III below) due to a substantiated medical condition directly related to the developmental disability. Definitions:

- "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.

- "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.

- "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.

- "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including

severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

- "Directly related to the developmental disability" means an illness, diagnosis, or syndrome occurred during the developmental period prior to age 22, is likely to continue indefinitely, and results in significant functional limitations in 3 or more areas of life activity. Illnesses or disability acquired after the developmental period, such as stroke or heart conditions, would not be considered directly related to the developmental disability.

- "Substantiated" means documented in the clinical/medical record, including the nursing notes.

Medical Criteria III – The beneficiary requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

Definitions:

- "Continuous" means at least once every 3 hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.

- Equipment needs alone do not create the need for skilled nursing services.

- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to, performing assessments to determine the basis for acting or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; injections; indwelling central venous catheter care; managing mechanical ventilation; oxygen administration and evaluation; and tracheostomy care.

Medicaid Provider Manual, Children's Special Health Care Services, Section 1, April 1, 2009

In this case, the Department determined that Appellant no longer met the eligibility criteria for PDN. The Department witness, [redacted], testified that the medical documentation submitted on Appellant's behalf did not establish his eligibility for PDN services on the basis that he does not meet Medical Criteria III. There's no dispute that Appellant has met Medical Criteria I at all times relevant to this matter. Therefore, the issue to be resolved is whether Appellant meets Medical Criteria III.

Appellant's legal guardians had the burden of establishing that Appellant met the eligibility criteria for PDN. On the other hand, the Department had the burden of going forward and establishing by a preponderance of evidence that it properly determined that Appellant did not meet the eligibility criteria for PDN during the time period in question. In this case, the Department failed to meet its burden of proof. Initially, [redacted] provided testimony, explaining why Appellant did not meet Medical Criteria III for PDN services. However, under questioning by this Administrative Law Judge, she failed to provide consistent testimony which explains clearly why Appellant does not meet Medical Criteria III. When asked does Appellant require "Continuous" care as defined in bullet 1 under Medical Criteria III, [redacted] answer was "yes." When asked whether Appellant requires "skilled nursing" care, [redacted] answer was "yes and no." When asked for an explanation for her "yes and no" answer, she testified that Appellant requires "skilled care" but that care does not have to be provided by a nurse. However, [redacted] failed to establish who, other than a nurse, would be able to provide the "skilled care" that Appellant needs. In addition, [redacted] testified that she was not aware that Appellant's parents were working. When asked by this Administrative Law Judge if this information would've affected the Department's eligibility determination, [redacted] answer was "yes."

This Administrative Law Judge gave controlling weight to Appellant's evidence which outweighs the evidence provided by the Department. Appellant's legal guardians, his mother and father, provided clear, consistent, detailed testimony regarding Appellant's need for continuous skilled nursing care. Appellant's parents testified credibly that Appellant is a toddler who has a habit of pulling out his tracheotomy, and he cannot be placed in day care because of the skilled nursing care that he requires on a daily basis. Appellant's RN and case manager, [redacted] testified as an expert witness and corroborated the testimony provided by Appellant's legal guardians. [redacted] explained clearly why a nurse is needed to provide the continuous skilled care that the Department's witness agreed is necessary to meet Appellant's medical needs. [redacted] testified that Appellant requires skilled nursing services for his equipment needs because he is a toddler who requires oxygen at times and is unable to turn on his tracheotomy suctioning machine or put his suctioning catheter into his airway to clear it if necessary. She testified that Appellant needs his tracheotomy at all times because he is creating secretions consistently, and he is fed orally and at a big risk for aspirations. [redacted] testified that Appellant requires the care of a trained nurse who is able to: evaluate when Appellant needs oxygen and have knowledge about a saturation monitor; know the amount of oxygen Appellant needs, pursuant to his doctor's orders; keep Appellant's airway clear and take out the sterile suctioning catheter to clear

Appellant's lungs when needed; know how to reinsert a tracheotomy after clearing Appellant's lungs; and know exactly what to do if Appellant's tracheotomy comes out. The aforementioned policy applicable to this case states clearly that skilled nursing care includes, but is not limited to, suctioning of the airway, oxygen administration and evaluation, and tracheostomy care.

In conclusion, the Department's evidence is insufficient to establish that Appellant does not meet the eligibility criteria for PDN. Therefore, the Department's eligibility determination cannot be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department failed to establish that Appellant did not meet the eligibility criteria for PDN services.

IT IS THEREFORE ORDERED that:

The Department's decision is REVERSED.

Marya A. Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/9/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules for the Department of Community Health will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.