STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-34380 CMH
Case No. [redacted]
Load No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, following the Appellant's request for a hearing.

After due notice, an in-person hearing was held on [redacted] [redacted] [redacted] appeared on behalf of their minor child, [redacted] (Appellant).

[redacted], Due Process Manager, represented [redacted] Health Services Provider [redacted], an agency contracted with the Department of Community Health (Department) to provide Medicaid-funded specialty mental health services and supports to Medicaid beneficiaries. Also appearing as witnesses for the Department were [redacted], Compliance Coordinator, [redacted] Regional Center ([redacted]; [redacted], Director of [redacted]; and [redacted] Psychology Services Supervisor, [redacted]

ISSUE

Has [redacted] properly determined the amount, scope and duration of the Appellant's medically necessary services, by providing private duty nursing services instead of CLS, as requested by the Appellant?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. Appellant is a [redacted] Medicaid beneficiary who resides in the family home and has been receiving specialty mental health services through [redacted], an

agency contracted with [redacted] to provide Medicaid-funded specialty mental health services to Medicaid beneficiaries.

2. The Appellant is ambulatory, and has a seizure disorder, speech, sight and motor skill impairments. He is vent-dependent at night and 1 hour on and 2 hours off during the day, and requires frequent suctioning. The Appellant attends school, and has been approved to receive 12 hours per day of private duty nursing (PDN) through Children's Special Health Care Services (CSHCS) since [redacted] However, the Appellant's parents have declined implementation of PDN, instead requesting increased respite and community living supports (CLS). *(Exhibit 1; p. 1)*

3. The Appellant was authorized for 90 hours per month and 2 overnights per month respite in [redacted] pending approval of PDN through CSHCS, and was reduced to 12 hours per week and 24 overnights per year after PDN was authorized. The Appellant's parents declined implementation of PDN, and then requested CLS to address behavioral issues related to removal of his tracheostomy tube.

4. [redacted] denied the request for increased respite and CLS following a [redacted] psychological assessment. The assessment found that a trained nurse would be better suited to deal with the both the behavioral issues (with training to be provided) and health issues than a CLS staff, as well as to monitor the Appellant's health issues during the night to allow the Appellant's parents to sleep. *(Exhibit 1; p. 1; 15)*

5. The Appellant is completely dependent on caregivers for all activities of daily living. For dressing/undressing, bathing, hair care, and oral hygiene, the Appellant is dependent and uncooperative. He is able to eat finger foods, but will often throw food given to him, and grabs other people's food. *(Exhibit 1; p. 13)*

6. Results of the Maladaptive Behavior Scale indicate the following challenging behaviors: self-injurious behavior (daily) in the form of biting and hitting himself; physical aggression (daily) in the form of biting, pulling hair, slapping and pushing others; property destruction (daily) in the form of throwing items that he can grasp; mouthing behaviors in the form of chewing on items (daily); tantrums (daily) in the form of crying, yelling; and unauthorized leave (once) in the form of going out the front door. *(Exhibit 1; p. 13)*

7. Other potential triggers for physical aggression are revealed when the Appellant is feeling ill, or tired, especially at night. The [redacted] assessment recommends PDN as an appropriate service to deal with the Appellant's behavioral issues, some of which affect his physical health (pulling out his tracheostomy tube). *(Exhibit 1; p. 15)*

8. On [redacted], the Appellant filed his Request for Hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

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.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services

> described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS), the Department of Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) Habilitation and Supports Waiver (HSW).

[redacted], a Prepaid Inpatient Health Plan (PIHP), contracts with the Michigan Department of Community Health to provide 1915(b) mental health services. The PIHP's contract with the Department requires that all services paid for with Medicaid funds must be medically necessary. [redacted]'s approval of PDN and denial of CLS services is based upon its determination that the provision of PDN is medically necessary, in that it more appropriately addresses the Appellant's unique behavioral problems and how those behaviors may require skilled nursing interventions, such as re-installing a tracheotomy tube. [redacted] has essentially determined that PDN, and not CLS, is an appropriate service, and is sufficient in amount, scope and duration to meet the Appellant's medically necessary needs as of the [redacted] assessment.

In performing the terms of its contract with the Department, the PIHP must apply Medicaid funds only to those services deemed medically necessary or appropriate. The Department's policy regarding medical necessity provides as follows:

> **2.5 MEDICAL NECESSITY CRITERIA**
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> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.
>
> **2.5.A. MEDICAL NECESSITY CRITERIA**
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> Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:
>
> - Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
> - Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
> - Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or

- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

Deny services that are:

- deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
- experimental or investigational in nature; or
- for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

Medicaid Provider Manual; Mental Health/Substance Abuse; Version Date: July 1, 2009; Pages 12-14

Community Living Supports (CLS)

Community Living Supports (CLS) facilitate an individual's independence and promote integration into the community. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings, and may not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:

- Assisting, reminding, observing, guiding or training the beneficiary with:
  - Meal preparation;
  - Laundry;
  - Routine, seasonal, and heavy household care and maintenance;
  - Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
  - Shopping for food and other necessities of daily living.

- Assistance, support and/or training the beneficiary with:
  - Money management;
  - Non-medical care (not requiring nurse or physician intervention);
  - Socialization and relationship building;
  - Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through DHS or health plan) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);
  - Leisure choice and participation in regular community activities;
  - Attendance at medical appointments; and
  - Acquiring procedure goods other than those listed under shopping and non-medical services

- Reminding, observing, and/or monitoring of medication administration.

The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

Michigan Department of Community Health
Medicaid Provider Manual
Mental Health/Substance Abuse; Version Date: October 1, 2008
Pages 76 and 77

1.5 Private Duty Nursing; GENERAL ELIGIBILITY REQUIREMENTS

The beneficiary is eligible for PDN coverage when all of the following requirements are met:

- The beneficiary is eligible for Medicaid in the home/community setting (i.e., in the non-institutional setting).
- The beneficiary is under the age of 21 and meets the medical criteria for PDN.
- PDN is appropriate, considering the beneficiary's health and medical care needs.
- PDN can be provided safely in the home setting.
- The beneficiary, his family (or guardian), the beneficiary's physician, the Medicaid case manager, and RN (i.e., from the PDN agency or the Medicaid enrolled RN, or the supervising RN for the Medicaid enrolled LPN) have collaborated and developed an integrated plan of care (POC) that identifies and addresses the beneficiary's need for PDN. The PDN must be under the direction of the beneficiary's physician; the physician must prescribe/order the services. The POC must be signed and dated by the beneficiary's physician, RN (as described above), and by the beneficiary or beneficiary's parent/guardian. The POC must be updated at least annually and must also be updated as needed based on the beneficiary's medical needs.

1.6 BENEFIT LIMITATIONS

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
Version Date: October 1, 2009; Page 4

The preponderance of the evidence presented supports [redacted]s decision to award 12 hours of private duty nursing services in lieu of CLS.

[redacted] the [redacted] Compliance Coordinator, testified that CLS is not necessarily the first choice of service for children of the Appellant's age. She indicated her office reviews issues such as whether the child is capable of bathing, dressing, grooming, eating and toileting to determine developmental delay. [redacted] credibly testified the Appellant's medical challenges outweigh his developmental delays, and that CLS personnel are not credentialed in performing skilled nursing assessments. She further testified that the Appellant's medical challenges, particularly his tendency to remove the tracheostomy tube, present issues by which skilled nursing assessments become crucial.

[redacted] the MORC Psychology Services Supervisor, also credibly testified she was involved in determining medical necessity for CLS, and determined that a nurse could also address the Appellant's behavioral challenges, while at the same time, attending to his medical needs.

The Appellant's mother testified only that private duty nursing is not the most appropriate service for the Appellant, because a nurse will show no compassion, and is only there to "collect a paycheck". She offered no further evidence for consideration.

DECISION AND ORDER

Based on a preponderance of evidence presented, I decide that [redacted] has appropriately determined the amount, scope and duration of the Appellant's medically necessary services, in this case, approving PDN and denying CLS.

IT IS THEREFORE ORDERED that:

[redacted] decision is AFFIRMED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

[redacted]
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Decision and Order

cc: [redacted]

Date Mailed: 11/18/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 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.