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

Appellant

______________________/

Docket No. 2009-5547 CMH
Case No.
Load

DECISION AND ORDER

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

After due notice, an in person hearing was held in on , . appeared on behalf of the Appellant. Her witnesses were (the parents and guardians) and . , represented (the Department). His witnesses were , and . Also in attendance was .

ISSUE

Did the Department properly propose to terminate the Appellant's 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 -year-old, developmentally disabled (DD) Medicaid beneficiary.

2. The Appellant is afflicted with quadriplegia, severe mental impairment and Anoxic encephalopathy. (See Testimony, Appellant's Exhibit #1 and Department's Exhibit A, p. 7)

3. The Appellant receives PDN services through the Habilitation and Supports Waiver (HAB) program.

4. The Appellant resides with her parents in the [redacted] service area.

5. The Appellant suffers from host of coma related impairments including; seizure activity, PEG tube feeding, skin hot spots and related maintenance issues. (See Department's Exhibit A, p.7 and Appellant's Exhibit #2 sub 6)

6. The Appellant's family and skilled nurses (LPN and RN) from [redacted] provide for her daily care.

7. The Appellant has been receiving 8 hours of skilled nursing services on a school day and 12 hours on a non-school day through the HAB waiver. (Department's Exhibit A, p. 7)

8. On [redacted], [redacted], completed a level of care (LOC) assessment of the Appellant for the purpose of determining [redetermination] continued qualification for PDN services. (Department's Exhibit A, pp. 3, 5)

9. On [redacted], [redacted], completed another LOC assessment of the Appellant. (Department's Exhibit A, pp. 41, 42)

10. The review of the Appellant's medical needs revealed that she did she did not meet the qualification criteria under the Medicaid Provider Manual. (Department's Exhibit A, pp. 2, 41)

11. The parties stipulated that the Appellant did not meet Medical Criteria I or Medical Criteria II. (See Testimony and written closing of Appellant)

12. On [redacted], the State Office of Administrative Hearings and Rules received the instant request for hearing.

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

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 Supports Waiver (HSW). contracts with the Michigan Department of Community Health to provide services under the HSW. Private Duty Nursing services are provided by Munson Home Services through pursuant to its contract obligations with the Department

The Medicaid Provider Manual also provides:

> Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the Pre-paid Inpatient Health Plan (PIHP) must be specified in his individual plan of services developed through the person-centered planning process.
>
> HSW beneficiaries must be enrolled through the MDCH enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/MR level of care services; and
- Chooses to participate in the HSW in lieu of ICF/MR services.

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Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

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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 nonmedical 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.

The HSW services cannot supplant Medicaid services. The beneficiary must use the DHS Home Help or Expanded Home Help services for assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living (bathing, eating, dressing, personal hygiene), and shopping.

> * CLS services may not supply state plan services, such as Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping in the beneficiary's own unlicensed home). If such assistance is needed the beneficiary, with the help of the PIHP supports coordinator, must request Home Help, and if necessary Expanded Home Help, from DHS. CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. The PIHP supports coordinator must assist, if necessary, the beneficiary in filling out and sending a request for a Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs based on the findings of the DHS assessment.
>
> CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the beneficiary's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training or these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

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> **Private duty nursing (PDN)** services are provided to individuals age 21 and older up to a maximum of 16 hours per day and consist of nursing procedures to meet an individual's health needs <u>directly</u> related to his developmental disability. PDN includes the provision of nursing treatments and observation provided by licensed nurses within the scope of the State's Nurse Practice Act consistent with physician's orders. The individual receiving PDN must also require at least one of the following rehabilitative services, whether being provided by natural supports or through the waiver:

- Community living supports
- Out-of-home non-vocational habilitation
- Prevocational or supported employment

PIHPs must find that the beneficiary meets Medical Criteria I or II.

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.

* * *

For beneficiaries described in II above, the requirement for frequent episodes of medical instability is applicable only to the initial determination for private duty nursing. A determination of need for continued private duty nursing services is based on the continuous skilled nursing care.

* * *

- "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.

> Licensed nurses provide the nursing treatments, observation, and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services.
>
> These services should be provided to a beneficiary at home or in the community. A physician's prescription is required.
>
> The PIHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Champus, Worker's Compensation, an indemnity policy, automobile insurance) for private duty nursing and will assist the beneficiary in selecting a private duty nursing provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary.
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> Medicaid Provider Manual (MPM), Mental Health [ ], §15, Habilitation Supports Waiver For Persons with Developmental Disabilities, January 1, 2009, pages 76 – 85.

The PIHP, in addition to meeting the above criteria is further bound by the general principles of medical necessity.

> The following medical necessity criteria apply to Medicaid mental health, <u>developmental disabilities</u>, and substance abuse supports and services.
>
> **[ ] MEDICAL NECESSITY CRITERIA**
> 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.
>
> **[ ] 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.
- Documented in the individual plan of service.

[ ] 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.

[ ] 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. (Emphasis supplied) MPM, §§2.5-2.5D, pages 12 – 14.

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The Department's witness, testified that she personally assessed the Appellant's home environment, medical records and nursing notes. She testified that the Appellant had neither medical instability nor hospitalizations during the period of review. She added that the Appellant's care needs were limited to oral suctioning and PEG feeding tube maintenance – neither service requiring skilled nursing. She noted in her report that no technically based equipment was in use and there was no need for continuous skilled nursing services per the evaluation criteria above. [Medical Criteria III *Supra*]

Department witness, , also testified that she conducted an LOC evaluation based on the guardian's appeal. The review period was through . She reviewed case notes and nursing notes and found no evidence of medical instability. She concluded – as did – that the Appellant does not need skilled nursing services. [*See generally,* Medical Criteria III]

stated that the Department stands ready to substitute CLS services for PDN services and that their action constitutes a replacement rather than an elimination of services.

The Appellant's representatives and witnesses brought cumulative testimony that the Appellant benefited from the daily skilled nursing assessments as a prophylactic hedge against her deteriorating physical condition or unrealized medical emergencies.

The Appellant's witness testified that the Appellant is [historically] a complicated case. She added that in her interactions with skilled providers for the Appellant she found that those licensed providers demonstrated important and continuous judgments which obviated emergency room visits or unrealized medical issues. Qualitatively she opined that skilled nursing would be better for the Appellant than non-skilled aides.

On review, it seems clear that the Appellant has benefited from skilled nursing services and could continue to benefit from those services. However, there was no preponderating demonstration of medical necessity for a skilled level of service versus an unskilled provision of services subject to supervision and medical protocols. The

testimony of Appellant's witness [redacted] was credible, but did not describe the standard of review under appeal today.

Private duty nursing is an increasingly scarce resource[1] which is nevertheless provided in Michigan when the care in issue is directly related to the disability and requires the experience and training of a Registered Nurse or a Licensed Practical Nurse. Private duty licensed nurses are not necessary for palliative standby duties or to merely activate the Emergency Medical System. True, licensed nurses are accountable to a regulatory body which builds a sense of a higher standard of care while bolstering consumer confidence - but there is no credible proof today that the necessary care for the Appellant cannot reasonably be achieved with properly trained, protocol-following, non-skilled staff. [2]

Not in issue today, but an important consideration, is that the assessment of the Department reviewers is not permanent. As the Appellant's physical condition ebbs and flows so might her care requirements. If and when the need for hands on, skilled nursing services becomes necessary [and physician directed] the CMH will be obligated to act. Furthermore, there are temporary PDN exceptions on both the beneficiary and the caregiver front when [subject to medical necessity] reimplementation of temporary PDN is demonstrated.

The Appellant's proofs were many and painted a positive picture of an attentive family and historically skilled care for the Appellant. However, there was inadequate, credible proof to show medical necessity for continued skilled nursing services.[3]

As manager [redacted] stated the Department stands ready to substitute – not eliminate services. Accordingly, the Department through the credible testimony of its RN witnesses established that skilled nursing services are not necessary for the Appellant. Other services would be sufficient in amount scope and duration to reasonably achieve the goals expressed in the Appellant's individual plan of service/person centered planning (IPOS/PCP).[4]

The ALJ is mindful of the Appellant's family and their proofs; however, the uncontested evidence establishes that the Appellant does not satisfy the medical necessity criteria to remain qualified for PDN based on review of the continuous skilled nursing care.[5] If in the future it is established the IPOS/PCP fails to meet its goals, the Appellant is free to request that the plan be altered. If that request is denied, she may request another hearing to present evidence that the PCP fails to provide needed medical services.

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[1] *See* Nurses as a scarce resource, Alberta, RN May/June 1999; Nursing industry desperate to find new hires, Dinesh Ramde, AP, 1-5-09.
[2] Credentialing of non-skilled staff is covered by the MPM/Mental Health, §§15.2 through 15.2D and must meet Michigan's 1915(c) Waiver staffing qualifications.
[3] Appellant's Ex #3 – was addressed and rebutted by Department RN reviewers whose testimony adequately assessed the Appellant's care needs and provider response. The exhibit failed to establish the need for skilled care - although it did demonstrate superior charting.
[4] *See* Department's Ex. A. pp. 43-45
[5] *See* MPM, §15.1 Medical Criteria II, p. 84

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly proposed to terminate Appellant's Private Duty Nursing (PDN) services.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: 3/4/2009

***** 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.