STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2010-3942 EDW
Case No. 41447522

[redacted],

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. The record was held open until [redacted], to allow briefing of the legal issues. The Appellant was represented by Attorney [redacted]. Testimony on behalf of the Appellant was presented by caretakers [redacted]. The Appellant was present and presented testimony on his own behalf.

The Department of Community Health was represented by its MI Choice waiver agent, [redacted] also testified on behalf of the Department. [redacted], was present as were [redacted] for the Department, and [redacted], for the Department of Community Health (hereafter, 'Department').

ISSUE

Did the Department properly deny the Appellant a request for an increase in personal care assistance, through the MI Choice waiver program?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] year old who is enrolled in the MI Choice Waiver program.

2. The Appellant is a ventilator dependant quadriplegic who resides with his wife in his own home. He weighs approximately [redacted].

3. The Appellant is completely dependent on aids to meet his medical and personal care needs.

4. The Appellant requires turning (or repositioning) in bed at least every two (2) hours.

5. The Appellant is at high risk for skin breakdown and currently has a stage four (4) pressure sore.

6. The Appellant has complex medical and personal care needs which include, among other things: wound care, tube feeding, suctioning and tracheotomy care, a bowel program, use of a lift for transfers and repositioning to address fluctuation in blood pressure.

7. The Appellant's services are delivered pursuant to a Special Memorandum of Understanding (SMOU) and include private duty nursing, counseling, fiscal intermediary, community living supports seven (7) days per week 24 hours per day, none of which are in dispute as to amount.

8. The Appellant services also include Community Living Supports (CLS) hours authorized in excess of 24 hours per day for four (4) days per week, two (2) hours per day, allowing for a second staff member to be present and aid in performing some of the personal care tasks.

9. The Appellant asserts he requires two (2) caretakers for the task of turning (in bed) and properly cleaning following a bowel movement if it occurs in bed.

10. The Appellant admitted at hearing he can "get by" with 36 hours of personal care per day.

11. The Department asserts the Appellant can be safely repositioned in bed with one (1) properly trained care provider.

12. Following his initial assessment and settlement agreement between the Department and the Appellant, the Department authorized a total of 196 hours per week of care for the Appellant. This authorization does not provide for two (2) paid caretakers to be present at all times, or even for the 36 hours the Appellant concedes he could "get by" with.

13. As part of the settlement agreement between the Department and the Appellant, the parties stipulated to an in-home demonstration of repositioning for the purpose of training caretakers in one (1) person turns of the Appellant.

14. The in-home demonstration was performed by a trained R.N. from [redacted] (a home care agency). The R.N. did not know the Appellant prior to the day scheduled for the demonstration.

15. The Maxim employee demonstrated a one (1) person turn of the Appellant and was available for questions by his caretakers, who were also present.

16. The Appellant, his family and caretakers are dissatisfied with the training, demonstration and determination by the Department that he can be safely turned by one (1) properly trained person.

17. The Appellant reports increased pain and anxiety when one (1) person turns him in bed compared to when two (2) caretakers are performing the task.

18. The Appellant requests the CLS hours authorized by the care plan be increased from 28 hours per day to 36 hours per day.

19. Claimant's exhibit 6, page 4 states "while the trainer demonstrated that he could physically turn [redacted], he did not show how that could be done safely and effectively by one person given all of [redacted] special circumstances and complex care needs".

20. No evidence of record establishes the one (1) person turn was medically unsafe or medically ineffective to accomplish the goal of physically turning the Appellant.

21. The Appellant's assertion that a one (1) person turn is the cause of fluctuating blood pressure is not corroborated by any medical evidence of record.

22. There is no medical evidence of record establishing the Appellant's physical health or safety is jeopardized by having one (1) person reposition him in bed.

23. The Department denied the Appellant's request for an increase in personal care hours from 28 to 36 per day, sending Notice of denial in [redacted]

24. The Appellant requested a hearing [redacted].

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.

This Appellant is claiming services through the Department's Home and Community Based Services for Elderly and Disabled (HCBS/ED). The waiver is called MI Choice in Michigan. The program is funded through the federal Centers for Medicare and Medicaid Services to the Michigan Department of Community Health (Department). Regional agencies, in this case [redacted], function as the Department's administrative agency.

Waivers are intended to provide the flexibility needed to enable states to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of recipients. Waivers allow exceptions to State Plan requirements and permit a state to implement innovative programs or activities on a time-limited basis, and subject to specific safeguards for the protection of recipients and the program. Detailed rules for waivers are set forth in subpart B of part 431, subpart A of part 440, and subpart G of part 441 of this chapter. *42 CFR 430.25(b)*

A waiver under section 1915(c) of the [Social Security] Act allows a state to include as "medical assistance" under its plan, home and community based services furnished to recipients who would otherwise need inpatient care that is furnished in a hospital, SNF [Skilled Nursing Facility], ICF [Intermediate Care Facility], or ICF/MR [Intermediate Care Facility/Mentally Retarded], and is reimbursable under the State Plan. *42 CFR 430.25(c)(2)*

Home and community-based services under section 1915(c) exist for a period of three years initially, and may be renewed thereafter for periods of five years. *42 CFR 430.25(h)(2)(i)*

CMS [Centers for Medicare and Medicaid Services] may grant a state an extension of its existing waiver for up to 90 days to permit the State to document more fully the satisfaction of statutory and regulatory requirements needed to approve a new waiver request. CMS will consider this option when it requests additional information on a new waiver request submitted by a state to extend its existing waiver or when CMS disapproves a state's request for extension. The MI Choice Waiver was last extended in Michigan in October of 2008.

*42 CFR 441.304(c)*1915 (c) (42 USC 1396n (c)) allows home and community based services to be classified as "medical assistance" under the State Plan when furnished to recipients who would otherwise need inpatient care that is furnished in a hospital SNF, ICF or ICF/MR and is reimbursable under the State Plan. 42 CFR 430.25(b)

Home and community based services means services not otherwise furnished under the state's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this subchapter. 42 CFR 440.180(a)

Included services. Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:

- Case management services.
- Homemaker services.
- Home health aide services.
- Personal care services.
- Adult day health services
- Habilitation services.
- Respite care services.
- Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.

Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization. 42 CFR 440.180(b). Michigan's approved waiver includes services in addition to those listed above. Community Living Supports is one of the approved MI-Choice waiver services.

The MI Choice Waiver contract update October 1, 2008, in Appendix C identifies community Living Supports as a participant Service. The Waiver contract specifies:

> Service Definition *(Scope):* Community Living Supports facilitate an individual's independence and promote reasonable participation in the community. Community Living Supports can be provided in the participant's residence or in community settings as necessary in order to meet support and service needs sufficient to address nursing facility level of care needs. Community Living Supports includes:
>
> A. Assisting* [see note below], reminding, cueing, observing, guiding and/or training in the following activities:
>
> - meal preparation
> - laundry

- routine, seasonal, and heavy household care and maintenance
- activities of daily living such as bathing, eating, dressing, personal hygiene
- shopping for food and other necessities of daily living

B. Assistance, support and/or guidance with such activities as:

- money management
- non-medical care (not requiring nurse or physician intervention)
- social participation, relationship maintenance and building community connections to reduce personal isolation
- transportation (excluding to and from medical appointments) from the participant's residence to community activities, among community activities, and from the community activities back to the participant's residence
- participation in regular community activities incidental to meeting the individual's community living preferences
- attendance at medical appointments
- acquiring or procuring goods and services necessary for home and community living
- Reminding, cueing, observing and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside and be supported in the most integrated independent community setting. When transportation incidental to the provision of community living supports is included, it shall not also be authorized as a separate waiver service for the beneficiary. Transportation to medical appointments is covered by Medicaid through the Department of Human Services (DHS). Community Living Supports do not include the cost associated with room and board. This service is authorized when necessary to prevent the institutionalization of the person served.

*Tasks that address personal care needs differ in scope, nature, supervision arrangements or provider type (including provider training and qualifications) from personal care services in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for community living supports tasks as provided under the waiver than the requirements for these types of services under the State Plan. Specify applicable (if any) limits on the amount, frequency, or duration of this service: Community Living Support services cannot be provided in circumstances where they would be a duplication of services available under the state plan or elsewhere available. The distinction must be apparent by unique hours and units in the approved care plan.

The amount of CLS authorized for the benefit of the Appellant is at issue in this case as identified by parties and at Page 4 of the Department's exhibit A.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. *See 42 CFR 440.230.* The MI Choice Waiver did not waive the federal Medicaid regulation that requires that authorized services be medically necessary.

Medicaid Fair Hearing rights are available to waiver program participants pursuant to Appendix 1 of attachment k to the waiver contract with the Department of Community Health. At Page 44, it states impertinent part:

> All Medicaid applicants and recipients have certain rights. This includes the right to a fair hearing. As a Medicaid provider, waiver agents have certain responsibilities related to the rights of persons applying for or receiving MI Choice services from them. This includes providing he applicant or participant with appropriate notice of their right to a fair hearing when the waiver agent takes an adverse action against them. For applicants and participants of the MI choice program, an adverse action occurs when, but is not limited to, situations where the waiver agent does any of the following:
>
> 1. Suspends or terminates participation in the MI Choice program;
>
> 2. Denies an applicant's request for participation in the MI Choice program
>
> 3. Reduces, suspends, terminates or adjust MI choice services currently in place;
>
> 4. Denies an applicant's or participant's request for MI Choice services that are not currently provided; or
>
> 5. Denies a participant's request for additional amounts of currently provided services.
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> Waiver Contract Attachment K, appendix 1 page 44 of 75.

The Appellant's CLS hours are authorized pursuant to the MI Choice waiver and are Medicaid benefits. He is entitled to a fair hearing where there is a dispute regarding the amount of services authorized if he believes they are inadequate to a meet his needs. He must demonstrate he is being denied medically necessary services in order to prevail.

DISCUSSION

The Appellant submitted exhibits 1-7, Brief, Reply Brief and typewritten testimony of family and caretakers, along with letters from his doctors. Additionally, medical opinions were submitted as appendices to the brief following hearing. The letters from the doctor and nurses submitted as appendices to the brief following hearing are excluded from the record as they were not introduced at hearing or stipulated to. The record was left open for the submission of the legal briefs addressing the possible jurisdictional issue and briefing the issue of medical necessity. It was not left open for the submission of additional evidence that was not subject to cross examination.

The evidence of record was carefully read and considered by this ALJ. The record did establish the Appellant's comfort is best served by two (2) person turns. Furthermore, it establishes his preferred and current caretakers do not like to do one (1) person turns and he does not like them to do it. His anxiety increases when he is being turned by one (1) person. The record is replete with written and verbal testimony from the Appellant, his family and non-medical license holding caretakers detailing the reasons he believes he requires two (2) people to turn him. They include, but are not limited to, managing ventilator hoses, possible need for clean up of bowel movements, sliding in the bed, lack of physical strength of the female caretaker compared to a male, the Appellant's weight and size, and his medical condition of autonomic dysreflexia. Additionally, much argument is accorded to criticism of the Department's legal presentation of their decision. This was also considered by this ALJ. However, ultimately, what the material, relevant evidence must establish in order for the Appellant to prevail is that it is medically necessary to have two (2) caretakers present to perform all turns. The evidence of record does not include any medical evidence of medical problem when turned by one (1) caretaker. No documentation was submitted supporting the assertion that the one (1) person repositioning is a cause of fluctuating blood pressure or any other medical problem. No documentation was submitted evidencing a medical complication or deterioration of the Appellant's condition as a result of having one (1) person turn or reposition him in bed. No doctor or nurse directly identifies a one (1) person turn as a medical risk. This ALJ is unable to rely on the lay testimony of the Appellant's lay caretakers or even the CNA testimony to find medical necessity for a two (2) person turn. Such a claim would have to be supported by medical documentation. The testimony of the caretakers and family members cannot be considered medical documentation.

The Department presented evidence it had engaged a home care agency for the purpose of demonstrating and training the Appellant, his family and caretaker that a turn can be accomplished with only one (1) staff person who is trained. An employee of [redacted] agency came to the Appellant's home and performed the demonstration of turning alone. The evidence of the demonstration was not presented directly by the person who performed the task, however, it is stipulated by the Appellant in the exhibits that was accomplished. See Finding of Fact # 19. There is also uncontested evidence of record that other ventilator dependent quadriplegic people who participate in the MI Choice Waiver program are turned by one (1) caretaker, including at least one (1) person weighing in excess of [redacted] pounds.

While evidence of the other Waiver participants was objected to as irrelevant and hearsay, it was found relevant by this ALJ for the purpose of educating about what is possible or not possible. Additionally, hearsay is allowed in administrative proceeding, thus the objection to it as hearsay is overruled.

This ALJ is moved by the Appellant's testimony concerning his anxiety, relative comfort when two (2) people turn him rather than one (1) person and preferences. However, the evidence of record, even that of the doctors which was admitted into the record, fails to establish it is medically necessary to have two (2) people turn the Appellant. After consideration of all of the evidence, this conclusion is supported, at least in part, by the admission from the Appellant himself at hearing that he can live with 36 hours of care rather than 48. If it is medically necessary to have two (2) people to safely perform a turn, then it is necessary for each and every turn, not just most of them. The admission that he currently has only one (1) caretaker for at least a part of everyday and could "live with" 12 hours of each day with only one (1) caretaker is counter to any assertion that two (2) caretakers are medically necessary for turning purposes. It is stipulated that turns are necessary every two (2) hours, thus there could not be more than a two (2) hour period of time without two (2) caretakers if it were actually medically necessary to have two (2) people turn the Appellant.

The hours of care currently authorized by the Department is adequate to reasonably achieve the program goals and meet the Appellant's medical needs. He is not without a caretaker at any time. He has two (2) caretakers provided to accomplish tasks it is undisputed requires two (2) people such as transferring for showering. He has private duty nursing and skilled wound care. It was stipulated at hearing the area of dispute was the authorization of hours to address his request for two (2) caretakers for turning. The Appellant did also assert that he requires two (2) people to properly clean up bowel movements that may occur in bed. This ALJ finds the evidence of his bowel program and plan of care addresses this need. This ALJ carefully considered the question raised concerning the Appellant's blood pressure during turns. While citing the Autonomic Dysreflexia as a reason to have two (2) caretakers present at all times, the medical evidence of record does not establish a one (1) person turn causes the fluctuation in blood pressure. The fact that it could occur during a turn was considered, however, there is no medical evidence that a one (1) person turn causes this condition or otherwise medically jeopardizes the Appellant's physical well being.

The Appellant asserted his set of medical conditions render him unique and that his size also renders the Department's plan inadequate. This was addressed by the evidence of record that there are other MI Choice Waiver participants who are ventilator dependent and quadriplegic who are cared for at home and by only one (1) caretaker at a time. Additionally, there is at last one (1) other who weights over [redacted] pounds, much more than the Appellant. Additionally, the fact that Appellant is unique does not render evidence of the circumstances faced by others irrelevant. It is relevant evidence of a medical standard that other similarly situated people are able to be turned by one (1) caretaker. Furthermore, participating in the Waiver program and self determination program does not

render the Appellant the only person qualified to determine what is appropriate to meet his medical needs. His autonomy and choices are important, however, the services authorization must still be for what is medically necessary to meet his needs.

This ALJ did consider the question of whether the anxiety and relative pain suffered by the Appellant are questions of medical necessity. I could not find support in Policy for making such a determination. While those issues may need to be otherwise addressed medically in the plan of care, they do not establish medical necessity for having two (2) caretakers present for turning the Appellant. The goals of the program are met by the authorization approved in the Special Memorandum of Understanding between the parties. I cannot find the Appellant has been denied a medically necessary service.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I find the Department properly denied the Appellant's request for an increase in personal care hours.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/31/2010

***** 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.