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:

Docket No. 2010-39508 EDW

[redacted],

Appellant
_______________________/

DECISION AND ORDER

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

After due notice, a telephone hearing was held on [redacted]. [redacted] appeared on her own behalf. [redacted], appeared as a witness for the Appellant. [redacted], appeared on behalf of [redacted], the Department's MI Choice program waiver agency (hereafter, Department). [redacted], appeared as a witness for the Department.

ISSUE

Did the Department properly terminate the Appellant's private duty nursing foot care services through the MI Choice Waiver program?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence on the whole record, I find as material fact:

1. The Appellant is a Medicaid beneficiary who has been receiving MI Choice Waiver services, including private duty nursing foot care.

2. The Appellant has multiple diagnoses and medical problems including macular degeneration, diabetes and neuropathy. (Exhibit 1, pages 10-11)

3. In [redacted], the waiver agency underwent a state audit. As a result of the audit, the waiver agency was informed that Medicaid does not automatically cover private duty nursing foot care. Medicaid does not cover private duty nursing for foot care, however, other options such as Medicare or Medicaid skilled care (Home Health)

may allow for coverage. (Exhibit 1, pages 25-27)

4. The Appellant has a Medicare identification number. (Exhibit 1, page 4)
5. On [redacted], the waiver agency conducted a re-assessment of the Appellant's case. (Exhibit 1, pages 3-19)
6. No foot problems were reported at the assessment. (Exhibit 1, page 14)
7. On [redacted], the waiver agency issued an Advance Action Notice to the Appellant indicating that the foot care service would be terminated. (Exhibit 1, page 23)
8. The Appellant's request for an administrative hearing was received on [redacted]. (Exhibit 1, page 24)

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.

Effective November 1, 2004, the Michigan Department of Community Health (MDCH) implemented revised functional/medical eligibility criteria for Medicaid nursing facility, MI Choice, and PACE services. Federal regulations require that Medicaid pay for services only for those beneficiaries who meet specified level of care criteria.

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 Health Care Financing Administration to the Michigan Department of Community Health (Department). Regional agencies, in this case the [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)*

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 HCFA:

- 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 HCFA as cost effective and necessary to avoid institutionalization. 42 CFR 440.180(b)

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.

The Medicaid Provider Manual addresses the medical criteria for private duty nursing (PDN) services:

2.3 MEDICAL CRITERIA

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 8 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 progressively debilitating physical disorder.

- "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 who is qualified to furnish such services and which 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 to place the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

- "Progressively debilitating physical disorder" means an illness, diagnosis, or syndrome that results in increasing loss of function due to a physical disease process, and that has progressed to the point that continuous skilled nursing care (as defined in III below) is required; and
- "Substantiated" means documented in the clinical/ medical record, including the nursing notes.

For beneficiaries described in II, the requirement for frequent episodes of medical instability is applicable only to the initial determination of medical necessity for PDN. Determination of continuing eligibility for PDN for beneficiaries defined in II is based on the original need for skilled nursing assessments, judgments, or interventions as described in III below.

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.

- "Continuous" means at least once every three 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.

***

2.5 EXCEPTION PROCESS

Because each beneficiary and his family are unique and because special circumstances arise, it is important to maintain an exception process to ensure the beneficiary's safety and quality of care. PDN services that exceed the beneficiary's benefit limitation, as established by the Decision Guide, must be prior authorized by the appropriate Medicaid case management program. Limited authority to exceed the published PDN benefit limitations may be granted on a time-limited basis as detailed below.

The beneficiary or his primary care giver must initiate the request for an exception. The applicable Medicaid case management program's representative is responsible for facilitating the request and documenting the necessity for an exception. Factors underlying the need for additional PDN must be identified in the beneficiary's POC, which must include strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception;
- Current lack of natural supports required for the provision of the needed level of support; and
- Additional PDN services are essential to the successful implementation of the beneficiary's written plan of care, and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his condition.

Medicaid Provider Manual,
Private Duty Nursing Section,
April 1, 2010, Pages 7-9, and 11-12

In the present case, no foot problems were documented at the time of the assessment. (Exhibit 1, page 14) The testimony indicated that the Appellant is not able to perform her own foot care, and would have trouble finding someone else to transport her to a podiatrist.

It was also noted that the foot soaks and lotioning she was receiving with the private duty nursing foot care have improved her dry and cracking feet.

The waiver agency Director testified that the foot soaks and lotioning could be arranged through other waiver services the Appellant receives, the CLS HHA. (See also Exhibit 1, page 21) Further, she explained that Medicaid is always a last resort and other insurance, such as the Appellant's Medicare, should be tried first.

The Medicaid Provider Manual also addresses other insurance:

> **1.4 OTHER INSURANCE**
>
> It is the responsibility of the family, private duty nursing agency, RN or LPN to assess, investigate and exhaust all commercial insurance for the beneficiary prior to billing Medicaid. A private duty nursing agency, RN, or LPN should not accept any Medicaid PDN case until it has been determined what, if any, commercial insurance a beneficiary may have.
>
> For any Medicaid case accepted in which the beneficiary has other insurance, he provider must first follow the rules of the other insurance. Such rules may include obtaining a physician's order, obtaining prior authorization, and being a participating provider with the other insurance carrier. Failure to follow the rules of the other insurance may result in nonpayment from Medicaid.
>
> If a beneficiary's commercial insurance does not cover PDN, the PDN agency, RN or LPN must inform MDCH of this prior to billing to expedite processing of the claim. A copy of the letter of explanation or explanation of benefits (EOB) must be faxed to MDCH Third-Party Liability. (Refer to the Directory Appendix for contact information.) Once it has been established that the commercial insurance does not cover PDN, a letter of explanation or EOB is valid as long as the insurance coverage remains unchanged. On an annual basis, the policyholder and provider should confirm with the commercial insurance that PDN coverage has not changed.
>
> *Medicaid Provider Manual,*
> *Private Duty Nursing Section,*
> *April 1, 2010, Pages 3-4*

While this ALJ sympathizes with the Appellant's circumstances, she does not qualify for private duty nursing foot care through the MI Choice Waiver. The Appellant does not meet

the medical criteria for private duty nursing, nor does she meet the medical necessity criteria for an exception based on the information available at the time of the assessment. Further, other options for coverage for these services should be explored. The Appellant has Medicare which may cover for the routine foot care (nail trimming) and the foot soaks and lotioning could be arranged through the other waiver services the Appellant receives, the CLS HHA.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MI Choice Waiver agency properly terminated private duty nursing foot care services.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: 9/15/2010

***** NOTICE *****
The Administrative Tribunal 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 Administrative Tribunal 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.