

**STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

██████████

Appellant

Docket No. 2011-4890 PAC
Case No. 32242034

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 ██████████. ██████████
██████████, appeared on behalf of the Appellant.
██████████, appeared as a witness for the Appellant. ██████████
██████████, appeared as a translator. ██████████
██████████ represented the Department. ██████████
██████████ appeared as a witness on behalf of the Department.

ISSUE

Did the Department properly decrease the Appellant's private duty nursing (PDN) hours?

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 ██████████ Medicaid beneficiary with anomalies of skull/facial bones. The Appellant has a tracheostomy and gastrostomy. (Exhibit 1, page 8)
2. The Appellant had been approved for Medicaid-covered PDN care 12 hours per day. (R.N./Private Duty Nursing Specialist Testimony)
3. On ██████████, the Appellant's PDN provider sent a letter to the Department indicating there had been changes to her plan of care that

may be cause for a review and reduction in hours. The plan of care was attached. (Exhibits 1, page 7-10)

4. The Appellant now uses the ventilator at night or when sleeping, but not during the day unless she is sick. (Exhibit 1, pages 7 and 10)
5. The Appellant began attending school in September five days per week from about ██████████. (Exhibit 1, pages 7)
6. On ██████████, the Department issued a Notification of Reduction/Termination of Private Duty Nursing services to the Appellant indicating the her PDN hours would be decreased from 12 to 10 hours per day because her ventilator requirement decreased. (Exhibit 1, pages 4-5)
7. On ██████████, the State Office of Administrative Hearings and Rules (SOAHR) received Appellant's request for a 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.

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. CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, in cooperation with the federal government under Title V of the Social Security Act and the annual MDCH Appropriations Act. 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 nonmedical program criteria.

An individual may be eligible for CSHCS and eligible for other medical programs such as Medicaid, Adult Benefits Waiver (ABW), 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, July 1, 2010

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.

*Medicaid Provider Manual, Private Duty Nursing,
Section 1, July 1, 2010*

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 caregiving 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).

*Medicaid Provider Manual, Private Duty Nursing,
Section 1.6, July 1, 2010.*

The medical criteria for PDN services are provided in the Medicaid Provider Manual, Private Duty Nursing in Section 2.3.

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,
Private Duty Nursing July 1, 2010*

In this case, there is no dispute that the Appellant meets the eligibility criteria for PDN. Rather the issue is decrease from 12 hours of PDN services per day to 10 hours of PDN services per day. This decrease was prompted by a letter from the Appellant's PDN provider indicating a reduction may be warranted based on changes to the Appellant's plan of care including decreased ventilator usage and attending school. (Exhibit 1, page 7) The ██████████, letter also noted that at that time, neither of the Appellant's ██████████ were working. (Exhibit 1, page 7) The decrease in ventilator usage was the basis for the reduction to the Appellant's PDN hours. (Exhibit 1, page 4 and ██████████ Testimony)

The Appellant's ██████████ disagrees with the reduction and testified that the Appellant needs the hours. The Appellant's ██████████ explained that she disconnects the Appellant from the ventilator because the Appellant is still on the vent after the nurse leaves. The Appellant's ██████████ also stated that she is going to start working because her ██████████ is not making enough money for the household, then both of the Appellant's ██████████ will be working. (██████████ Testimony)

Based on the documentation submitted to the Department in ██████████, there was a change in the Appellant's medical condition or needs. The Department authorized PDN hours based on the Appellant's needs for skilled nursing services. Part of the Appellant's need for skilled nursing is due to her ventilator requirement. The reduced ventilator usage supports the decreased need for PDN hours. This does not imply that the Appellant does not need services. Other services may be available to the Appellant to meet her needs that do not require skilled nursing. The Appellant's ██████████ indicated she would assist with looking into what other services may be available to the Appellant. Further, the Appellant can always submit a request to the Department for an increase in PDN hours with supporting documentation if there is a change in her medical condition or needs requiring skilled nursing services.


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Decision and Order

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly reduced the Appellant's PDN hours based on the available information.

IT IS THEREFORE ORDERED that:

The Department's decision is **AFFIRMED**.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc:



Date Mailed: 1/24/2010

***** 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 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.