STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

Docket No. 2012-21485 HAB

[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 hearing was held on [redacted]. [redacted], Appellant's care provider, appeared and testified on Appellant's behalf. [redacted] and [redacted] also testified as witnesses for Appellant. [redacted], Hearings Officer, appeared and testified on behalf of Community Mental Health for Central Michigan (the "CMH"). [redacted]y and [redacted], both registered nurses, testified as witnesses for the CMH. Other CMH employees were present during the hearing, but did not participate.

ISSUE

Did the CMH properly determine that Appellant is ineligible for private duty nursing (PDN) through the Habilitation Supports Waiver?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Appellant is a [redacted] year-old woman who born on [redacted]. (Exhibit 3, page 1).

2. Appellant has been diagnosed with cerebral palsy, spastic quadriplegia, asthma, respiratory insufficiency, mental retardation, adrenal insufficiency, adrenal hyperplasia, regional pain syndrome, elevated blood pressure, right hip dislocation, a history of strokes, microcephaly, and sinusitis. (Exhibit 10, pages 1-4).

3. The CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the CMH service area.

4. Appellant was receiving PDN through the CMH as a Medicaid benefit. However, per the Medicaid Provider Manual (MPM), that benefit is only for beneficiaries under the age of 21 who meet the medical criteria in this section. (Testimony of [redacted] MPM, Private Duty Nursing Section, October 1, 2011, page 1).

5. For beneficiaries 21 and older, PDN is a waiver service that may be covered for qualifying individuals enrolled in the Habilitation Supports Waiver or MI Choice Waiver. (MPM, Private Duty Nursing Section, October 1, 2011, page 1).

6. As Appellant's [redacted]st birthday approached, the CMH decided to conduct a determination to see if she would be eligible for PDN through the Habilitation Supports Waiver. (Testimony of [redacted]).

7. [redacted] assessed Appellant on [redacted] and made a determination on [redacted] that Appellant was eligible for PDN. (Exhibit 3, pages 1-3).

8. However, during a review of that determination, the CMH ultimately decided that Appellant was not eligible for private duty nursing. (Testimony of [redacted]; Testimony of [redacted]).

9. On [redacted], the CMH sent a notice to Appellant notifying her that private duty services were going to be terminated because she does not qualify for those services. The effective date of the termination was identified as [redacted], but the notice also described a transition period of 60 days, between [redacted] and [redacted]. (Exhibit3, pages 1-3).

10. The Michigan Administrative Hearing System (MAHS) first received Appellant's Request for Hearing on [redacted]. However, that request was only signed by Appellant's parents and they did not provide any documentation that they are Appellant's legal guardian. Subsequently, on [redacted] MAHS received a request for hearing signed by Appellant. (Exhibit 6, page 1).

11. After Appellant sent in the Request for Hearing, the CMH conducted another PDN eligibility determination. The assessment was completed on [redacted] by [redacted] and the determination made [redacted], 2012. (Exhibit 3, pages 4-5).

12. The CMH, through [redacted], again found that Appellant was ineligible for PDN. (Exhibit 3, pages 4-5).

13. On [redacted], the CMH sent Appellant another notice stating that she did not qualify for PDN and that service would be terminated. The effective date of the termination was identified as [redacted]. (Exhibit 5,

pages 3-4).

14. The CMH has not yet implemented any termination and is waiting for a decision on Appellant's appeal. (Testimony of Bondale; Testimony of Williams).

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…
>
> (42 USC 1396n(b))

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) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. The Medicaid Managed Specialty Services and Support program waiver operates, in conjunction under section 1915(c), with the Habilitation Supports Waiver (HSW). The HSW is designed to provide specified home and community based services to enrolled participants. The waiver services are available to enrolled beneficiaries who would, absent the waiver, require intermediate care facility placement. The CMH contracts with the Michigan Department of Community Health to provide services under the Habilitation and Supports waiver, Managed Specialty Service and Supports Waiver and other State Medicaid Plan covered services. Services are provided by the CMH pursuant to it contract obligations with the Department.

The Medicaid Provider Manual (MPM), Mental Health/Substance Abuse Section, articulates the relevant policy and, with respect to HSW, it states:

> **SECTION 15 – HABILITATION/SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**
>
> 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 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.

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDCH Bureau of Community Mental Health Services. (Refer to the Directory Appendix for contact information.)

(MPM, Mental Health/Substance Abuse Section, January 1, 2011, page 82)

Specifically, with respect to PDN through the HSW, the MPM provides:

Private Duty Nursing (PDN)

Private Duty Nursing (PDN) services are skilled nursing interventions provided to individuals age 21 and older, up to a maximum of 16 hours per day, to meet an individual's health needs that are directly related to his developmental disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the written health care plan which is part of the beneficiary's individual plan of services (IPOS). PDN services are for beneficiaries who require more individual and continuous care than

> periodic or intermittent nursing available through state plan services, e.g., Home Health. The individual receiving PDN must also require at least one of the following habilitative services, whether being provided by natural supports or through the waiver.
>
> - Community living supports
> - Out-of-home non-vocational habilitation
> - Prevocational or supported employment
>
> To be determined eligible for PDN services, the PIHP must find that the beneficiary meets Medical Criteria I as well as Medical Criteria III, or meets Medical Criteria II as well as Medical Criteria III. Regardless of whether the beneficiary meets Medical Criteria I or II, the beneficiary must also meet Medical Criteria III.
>
> (MPM, Mental Health/Substance Abuse Section, January 1, 2011, page 91)

Here, it is agreed by both sides that Appellant meets Medical Criteria I and that the only dispute is whether Appellant meets Medical Criteria III. With respect to meeting Medical Criteria III, the MPM provides:

> **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, and documentation to support the frequency and scope of those decisions or actions;

> managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the beneficiary four or more hours per day;

> deep oral (past the tonsils) or tracheostomy suctioning;

> injections when there is a regular or predicted schedule, or prn injections that are required at least once per month (insulin administration is not considered a skilled nursing intervention);

> nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;

> total parenteral nutrition delivered via a central line and care of the central line;

> continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below;

> monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

(Mental Health/Substance Abuse Section,
January 1, 2011, pages 93-94)

Appellant's representative argues that Appellant meets Medical Criteria III and requires skilled nursing care during the night. As testified to by Appellant's witnesses and documented in the evidence she submitted, the private duty nurse provides extensive services during the night. Those services include monitoring and assessing Appellant's Bipap/heart rate, adrenal deficiency, oxygen, seizures, and medications. Appellant's representative does, however, acknowledge that not everything the nurses do is documented or written down in a specific doctor's order. Appellant's representative also noted that Appellant's life revolves around "what if" scenarios" such as seizures and other crises, and that a private duty nurse needs to be there given the danger of emergencies occurring.

Respondent, on the other hand, argues that the record does not document any need for skilled nursing during the night. While Respondent acknowledges that Appellant multiple needs throughout the night, it also asserts that a skilled/trained direct care worker can provide the needed services. In particular, [redacted] argued that services are not based on what could happen and, instead, are based on the documented need for services. [redacted] also specifically testified that nurses are being told what to do by doctors rather than exercising their own judgment and that there is no documented need for private duty nursing in the record.

It is undisputed that Appellant has significant and complex medical issues. However, even Appellant's parents concede that they can take care of Appellant during the day and that the nurses do not do anything different at night. If Appellant's parents can provide appropriate care during the day despite the fact they are not trained nurses and essentially the same care is needed during the night, then there is no need for skilled nursing care during the night. The mere fact that the nurses have been providing satisfactory care during the night and that Appellant's parents are more comfortable with having nurses there does not mean that such skilled care is medically necessary.

Moreover, the undisputed fact that some training is required before a person would be qualified to care for Appellant during the night also does not mean that skilled nursing care is required. As demonstrated by Appellant's parents, non-nurses can be trained to provide the appropriate amount of care. The CMH's representative also noted that services were not being removed completely or immediately. Instead, there would be a transition period during which the private nurses were phased out and trained aides brought in.

This Administrative Law Judge finds that Appellant does not require continuous skilled nursing care on a daily basis during the time when a licensed nurse was being paid to provide services. Accordingly, she does not meet Medical Criteria III and the CMH's determination that PDN is not medically necessary must be affirmed.

During the hearing, Appellant's representative and parents expressed a number of concerns regarding how the transitions would be made from private duty nursing and the difficulty in finding aides that could provide appropriate care during the night. However, while those concerns were discussed during the hearing, they are an issue for another time. With respect to the issue regarding PDN before this Administrative Law Judge, Appellant does not qualify for such services and the CMH's decision must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly terminated the private duty nursing.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Steven J. Kibit
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4-27-12

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.