STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 2013-13560 PAC
Case No. [redacted]

Appellant
_____/

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.

A pre-hearing conference was held on [redacted]. After due notice, a hearing was held [redacted]. [redacted], Attorney, and [redacted], Attorney, represented the Appellant. [redacted], mother and Guardian, appeared as a witness for the Appellant. [redacted], Appeals Review Officer, represented the Department. [redacted], R.N./Private Duty Nursing Specialist, appeared as a witness on behalf of the Department.

ISSUE

Did the Department properly deny the Appellant's prior authorization request for 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 [redacted] year-old Medicaid and Children's Special Health Care Services beneficiary with multiple diagnoses, including cerebral palsy, dystonia and short gut syndrome. (Exhibit 1, pages 13 and 21; Exhibit D; Exhibit F)

2. On or about [redacted], the Department received a prior authorization request for PDN services for the Appellant. (Exhibit 1, page 14)

3. On [redacted], the Department issued a Notification of Denial of Private Duty Nursing Services to the Appellant. The Notice indicated PDN services were denied based on medical review of the submitted documentation, which determined the Appellant does not meet medical criteria for authorization of PDN hours at that time. The notice further advised that the Appellant's status may meet criteria in the future and re-application can be made at any time. (Exhibit 1, page 14)

4. On [redacted], the Appellant's hearing request was received by the Michigan Administrative Hearing System. (Exhibit J)

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, October 1, 2012*

General information regarding Private Duty Nursing (PDN) may be found in the Department's Medicaid Provider Manual, Private Duty Nursing, Section 1.

> 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 in this manual.
>
> 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 Waiver (the Community Mental Health Services Program)
> - Habilitation Supports Waiver (the Community Mental Health Services Program)
> - Home and Community-Based Services Waiver for the Elderly and Disabled (the MI Choice Waiver)
>
> For a Medicaid beneficiary who is not receiving services from one of the above programs, the Program Review Division 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., Children's Waiver, Habilitation Supports Waiver, MI Choice Waiver).
>
> 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. 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, October 1, 2012.*

The Medicaid covered PDN service limitations are provided in the Medicaid Provider Manual, Private Duty Nursing, Section 1.7.

> 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 or more 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 1.7, October 1, 2012.*

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 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.
>
> *Medicaid Provider Manual, Private Duty Nursing*
> Section 2.3, October 1, 2012

Quite a bit of additional information has been submitted to the Department since the [redacted] denial, and a new prior authorization request was made in late [redacted]. Additional information was even submitted at the time of the [redacted] prehearing conference. However, this hearing is limited to reviewing the [redacted] denial. The R.N./Private Duty Nursing Specialist indicated that the Department is still reviewing the recently submitted documentation. The Department had not made a new determination as of the [redacted] hearing date, but will be issuing a Notice of their determination on the current review of PDN services for the Appellant. A new hearing request can be filed to contest the Department's determination, or failure act upon the request with reasonable promptness, if needed.

In this case, the Department determined that the Appellant did to meet either Medical Criteria I or Medical Criteria II based on the information submitted at the time of the [redacted] determination. The R.N./Private Duty Nursing Specialist testified that the main reason for the denial was that the Appellant did not have a central line in place at that time. The information submitted did not indicate the Appellant was dependant daily on any of the other technology based medical equipment listed in Medical Criteria I nor that he met Medical Criteria II. (R.N./Private Duty Nursing Specialist Testimony) Accordingly, the Department issued the Notification of Denial of Private Duty Nursing Services indicating PDN services were denied based on medical review of the submitted documentation, but advising that the Appellant's status may meet criteria in the future and re-application can be made at any time. (Exhibit 1, page 14)

While the evidence submitted for this hearing includes numerous documents that were submitted after the [redacted] denial determination, it is clear that the Appellant did not have a central line in place in [redacted]. Rather, the Appellant's central line was removed [redacted] due to infection and a new central line was not placed until [redacted]. (Exhibit 1, page 59, Exhibit G, Exhibit L) Therefore, at the time of the [redacted] determination, the Appellant could not have met Medical Criteria I based on receiving total potential nutrition via a central line, associated with complex medical problems or medical fragility.

The R.N./Private Duty Nursing Specialist credibly testified the information submitted for the October 2012 review did not indicate the Appellant was dependant daily on any of the other four types of technology based medical equipment listed in Medical Criteria I. (R.N./Private Duty Nursing Specialist Testimony) In the Appellant's brief, two of the other four types of technology based medical equipment listed in Medical Criteria I are addressed. However, the documentation submitted to support the need for continuous oxygen administration and monitoring by pulse oximeter was dated [redacted], well after the [redacted] denial. (Exhibit Q) When the Appellant was without the central line in [redacted] through [redacted], nutrition and medications were administered through a surgically implanted G tube. (Exhibits R and S) This ALJ does not doubt that the Appellant's medical condition was fragile, and significant care was required during this time. However, nutrition and medications administered via a surgically placed G tube is not the same as having nasogastric tube feedings or medications where removal and insertion of the nasogastric tube is required, as listed under medical Criteria I.

Regarding Medical Criteria II the documentation submitted to establish that the Appellant met these requirements is from [redacted] through [redacted]. (Exhibits K-N and V-W) Again the bulk of this information was not available at the time of the [redacted] determination.

Based on the information available at the time of the [redacted] determination, the Appellant did not meet the requirements of either Medical Criteria I or Medical Criteria II. Accordingly, there is no need for this ALJ to review the Medical Criteria III because the policy requires meeting either Medical Criteria I and III or II and III to qualify for PDN services at that time. The Department properly denied the Appellant's prior authorization request for PDN services based on the available information.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's prior authorization request for PDN services based on the available information.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

\s_____
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[redacted]
Docket No. 2013-13560 PAC
Decision and Order

cc: [redacted]

Date Mailed: 2/13/2013

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.