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:

Docket No. 2012-65923 PAC
Case No. [redacted]

[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.

After due notice, a hearing was held [redacted]. [redacted], mother, appeared on behalf of the Appellant. [redacted], Case Manager, appeared as a witness for the Appellant. [redacted], Manager Appeals Section, represented the Department. [redacted], R.N./Private Duty Nursing Specialist, 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 a [redacted] year-old Medicaid beneficiary with diagnoses of: spina bifida with hydrocephalus; chronic respiratory failure; other anomalies of larynx, trachea, and bronchus; and dependence on respirator, status. (Exhibit 1, pages 20-21)

2. On [redacted], the Appellant was approved for Medicaid-covered PDN care, 16 hours per day. Exhibit 1, page 10)

3. On [redacted], the Appellant's PDN provider sent a request for renewal of PDN services to the Department. (Exhibit 1, page 20)

4. On , the Department issued a Notice of Authorization to the Appellant indicating that her PDN hours would be decreased transitionally from 16 hours per day from thru , to 12 hours per day from thru and then 10 hours per day from thru . The Notice indicated this was based on the Appellant not being on the vent 24 hours per day as the Plan of Care indicated she remains off the vent during awake hours. (Exhibit 1, pages 8-9)

5. On , the Appellant's hearing request was received by the Michigan Administrative Hearing System. (Exhibit 1, pages 4-9)

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, 2011

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, July 1, 2011.

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 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 1.6, July 1, 2011.

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, July 1, 2011

In this case, there is no dispute that the Appellant meets the eligibility criteria for PDN. Rather the issue is decrease from 16 hours of PDN services per day to 10 hours of PDN services per day, with the transitional step at 12 hours of PDN services per day. This decrease was based on the changes in the Appellant's condition since she started PDN services. The information provided to the Department included a plan of treatment, which noted:

> Client remains safe in her home, as evidenced by no reported unplanned hospitalizations or trach dislodgements over the past 60 days. There have been no reported episodes of respiratory crisis/infections. Vent weans have progressed without issue. Client is now off vent support at all times while awake. Client has also successfully weaned off nocturnal oxygen.
>
> (Exhibit 1, page 32)

The Department reviewed the available information and determined that there have been improvements in the Appellant's condition. The skilled nursing hours were reduced in light of the Appellant's lesser respiratory needs, to 10 hours per day with an incremental step at 12 hours per day. (R.N./Private Duty Nursing Specialist Testimony)

The Appellant's mother disagrees with the reduction, but acknowledged that she was aware the PDN authorization would not always remain at the initial 16 hours per day. The Appellant's mother is seeking less of a reduction because the loss of 6 hours per day is very difficult. She is a single mother who works full time and there are no backup caregivers at this time. Fatigue is a serious concern both in her work as a nurse and in caring for the Appellant. Finding any potential caregivers is difficult due to the Appellant's complex and fragile medical condition. The Appellant requires constant, diligent, skilled care. Even with the gains the Appellant has made, the underlying medical condition is always present. There is a risk of central apnea at any time. The Appellant attends school, but she must have a nurse with her. Further, the Appellant's mother has had some health complications of her own, and will need to have knee replacement surgery. The Appellant's Case Manager also expressed concerns with the

submitted forms being completed correctly and the completeness of the information provided to the Department. (Mother and Case Manager Testimony)

Based on the documentation submitted to the Department, there was a change in the Appellant's medical condition or needs since she started receiving PDN services. While this ALJ understands the gains the Appellant has made with her respiratory status have only been possible due to the exceptional care that has been provided, the Department provided sufficient evidence to support the reduction of PDN hours. The Department authorizes PDN hours based on the Appellant's needs for skilled nursing services. Part of the Appellant's need for skilled nursing services is due to her ventilator requirement, which has decreased. The Department's determination to decrease the Appellant's PDN hours from 16 hours per day to 12 hours per day, then 10 hours per day is supported by the available information.

This does not imply that the Appellant does not need assistance or would never be eligible for an increase in PDN hours. Further, during the telephone hearing proceedings, circumstances that would support even temporary increases in PDN hours were discussed. 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, needs, or circumstances requiring additional skilled nursing services.

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.

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

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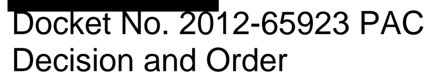

Date Mailed: __2/4/2013___

***** 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.