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. 14-018395 CMH

[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] Appellant's father appeared on Appellant's behalf. Appellant's mother [redacted] and [redacted], RN, Director of Clinical Services, [redacted] also testified on the Appellant's behalf. Appellant was present for the hearing but did not testify.

[redacted], Due Process Manager, appeared on behalf of [redacted] County Community Mental Health Authority (CMH), representing the Department. [redacted] RN, BSN, Nursing Supervisor, [redacted] Inc., testified for the CMH.

ISSUE

Did CMH properly determine that the Appellant was ineligible for private duty nursing (PDN) through the Habilitation Supports Waiver and authorize a transition plan calling for PDN services at 6 hours per day for the next three months?

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 A, p. 6).

2. Appellant has been diagnosed with several medical conditions including scoliosis, Myotonic disease, and Myofibrillar Myopathy, which have

caused heart complications, conduction disorder, respiratory abnormalities, and tracheotomy complications. Appellant has a ventilator and a G-tube. (Exhibit A, pp. 7, 21).

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 [redacted] hours per day of PDN under the Habilitation Supports Waiver (HSW) as a Medicaid benefit in a self-determination arrangement through [redacted], CMH's contractor for persons with developmental disabilities. (Exhibit A, pp. 1, 8, 10 and testimony).

5. On [redacted]r, RN, BSN, reassessed Appellant and made a determination on [redacted] that Appellant was not eligible for PDN. [redacted] found that the Appellant did not meet Criteria III as she did not require continuous skilled nursing care on a daily during the time when a licensed nurse was being paid to provide services. The nursing notes for the Appellant did not reflect that there were skilled nursing interventions occurring at least every [redacted] hours during the time when a licensed nurse was being paid to provide the services. [redacted]r did not want to go from [redacted] hours per day to 0 hours, so she recommended a reduction to the low category or [redacted] hours per day, and to do another review of the nursing notes in [redacted] months. (Exhibit A, pp, 8, 30-48).

6. On [redacted] sent a notice to Appellant notifying her that private duty services and respite care – hourly, were going to be authorized for a limited time ([redacted]) to determine medical necessity of the servicers. (Exhibit A, pp. 3-4).

7. A new Individual Plan of Service (IPOS) for the Appellant was developed for the period of [redacted] through [redacted]. The IPOS includes an authorization for a step down or a transition plan for PDN services at the rate of [redacted] hours per day for the next [redacted] months with another PDN review at the end of the three month period. (Exhibit A, pp. 8, 13

8. On [redacted], the Michigan Administrative Hearing System (MAHS) received Appellant's Request for Hearing appealing the approval of PDN at [redacted] hours per day for a limited time. (Exhibit 1).

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)**
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> 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
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> 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, October 1, 2014, p. 105, emphasis added).

Here, it is undisputed 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. (MPM, Mental Health/Substance Abuse Section, October 1, 2014, pp. 107-108, emphasis added).

* * *

In the event that a transition plan has been developed wherein PDN services are to be reduced or eliminated based on a determination of medical necessity, the PIHP may provide PDN for a period of time (not to exceed three months) for the purpose of training the CLS or respite aides or family and assuring a smooth transition. In those cases, the transition plan, including amount, scope, frequency and duration of the training by nurses to aides, must be documented in the IPOS. A transition process is not intended to provide two-to-one (nurse and aide) staffing for any purpose other than for training (with limitations on duration and frequency noted in the IPOS) while the aide or family member becomes familiar with the beneficiary's care needs. This transition period is only permitted when it has been determined that PDN is not medically necessary and the beneficiary's care needs can be met by a trained CLS or respite aide. (MPM, Mental Health/Substance Abuse Section, October 1, 2014, p. 111, emphasis added).

Appellant's representative argues that Appellant meets Medical Criteria III and requires PDN services. Appellant's witnesses provided testimony in an attempt to show that the nursing notes kept by the private duty nurses from [redacted] documented the need for continuous skilled nursing care on a daily basis during the time when the licensed nurses were being paid to provide services. [redacted] urged that in addition to the deep oral or tracheostomy suctioning documented in their nursing notes, the nurses were also checking to make sure the Appellant's ventilator was working properly and doing respiratory assessments which amounted to assuring

that the Appellant was breathing properly and was not having any problems breathing. She also noted it was documented in the nursing notes that on one occasion a tube became disconnected causing an alarm to go off and the tube had to be reconnected. Appellant's mother testified that she thought the Medicaid policy for Criteria III indicates a person meets the criteria if deep oral or tracheostomy suctioning is required, without specifying a number of times it would be needed in order to meet this criterion. She also noted the nurses take the Appellant's blood pressure and the Appellant has an ICD defibrillator that needs to be monitored.

Respondent, on the other hand, argues that that the nursing notes kept by the private duty nurses from [redacted] do not document the need for continuous skilled nursing on a daily basis as defined by the policy in the MPM. Respondent's documentary evidence established that on [redacted], RN, BSN, with [redacted] reassessed Appellant and made a determination on [redacted] that Appellant was not eligible for PDN. [redacted] found that the Appellant did not meet Criteria III as she did not require continuous skilled nursing care on a daily during the time when a licensed nurse was being paid to provide services. Nurse Hoopingarner found that the nursing notes for the Appellant did not reflect that there was skilled nursing intervention occurring at least every [redacted] hours during the time when a licensed nurse was being paid to provide the services.

Respondent's witness, [redacted], [redacted] Nursing Supervisor stated she did a review of [redacted] eligibility determination worksheet in this case. She also reviewed the Appellant's plan of care, the nursing assessment completed by the PDN agency, the RN supervisory visits, nursing notes, flow sheets, medication records, and she spoke with [redacted] and her nursing supervisor at the time of the review. After reviewing the nursing notes for [redacted] nursing shifts, for a total of [redacted] hours of private duty nursing hours, [redacted] stated she did not find that the nursing notes documented continuous skilled nursing on a daily basis as defined by the policy in the MPM. She stated that tracheostomy suctioning was the only skilled nursing service documented in the nursing notes. [redacted] determined that there were only [redacted] documented episodes of skilled nursing interventions in the [redacted] hours reviewed, or one skilled nursing intervention every [redacted] hours. [redacted] stated Appellant did not qualify for PDN under the HSW, meeting Criteria I, but not Criteria III.

In response to the testimony of the Appellant's witnesses, [redacted] stated that monitoring the ventilator or the defibrillator without more does not constitute a skilled nursing intervention. She stated reconnecting the tubing that came undone would not be a skilled nursing intervention. She also noted that the Appellant's vitals, including her blood pressure were being taken only once or at most twice during a [redacted] hour nursing shift, and taking her vitals, including taking her blood pressure, does not require skilled nursing care.

The respondent's testimony and documentary evidence is supported by the highlighted portions of the policy quoted above. The policy states that equipment needs alone do

not create the need for skilled nursing. Something more than just the monitoring of said equipment is required to qualify as a skilled nursing assessment or intervention. The policy quoted above indicates that skilled nursing means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. An assessment is more than just monitoring the needed equipment, or checking to see if the Appellant is breathing properly. It must include the skilled nurse's determination of the need or justification for a nursing intervention. For example, for continuous oxygen administration, adjustments to oxygen administration according to a written protocol are not considered a skilled nursing intervention. The policy also states that the mere taking of vitals, routine blood pressure and pulse, at least once every [redacted] hours during a nursing shift is not considered skilled nursing care.

This Administrative Law Judge finds based upon the preponderance of the evidence that the Appellant does not require continuous skilled nursing care on a daily basis during the time when a licensed nurse is 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. According to the Medicaid policy quoted above, it was proper for CMH to develop a transition plan in the Appellant's new IPOS for three months, to step down from the [redacted] hours of PDN previously authorized and to allow time for training CLS or respite aides or family members to provide for the Appellant's care. This would assure a smooth transition from the PDN services, and also allow for a possible reassessment of the Appellant's need for services before an actual termination of PDN services occurs.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly determined the Appellant was ineligible for private duty nursing (PDN) through the Habilitation Supports Waiver and authorized a transition plan in her new IPOS calling for PDN services at [redacted] hours per day for the next three months.

IT IS THEREFORE ORDERED that:

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

William D. Bond
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed [redacted]

[redacted]
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WDB/db

cc: [redacted]

***** 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.