STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARINGS 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]

Appellant
_____/

Docket No. 15-001496 EDW
Case No. [redacted]

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 Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted], Appellant's mother/guardian, appeared and testified on Appellant's behalf.

[redacted], R.N., Program Director, appeared and testified on behalf of the Department's MI Choice Waiver Agency, [redacted] Care Management [redacted] or Waiver Agency). [redacted], RN Case Manager, and [redacted], Social Worker, Case Manager, appeared as witnesses.

ISSUE

Did the Waiver Agency properly deny Appellant's request for 24/7 Private Duty Nursing (PDN) services or, in the alternative, additional Community Living Supports (CLS) and respite in the home?

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 Department contracts with [redacted] Management to provide MI Choice Waiver services to eligible beneficiaries. (Exhibit A, pp 9-10; Testimony)

2. The Waiver Agency must implement the MI Choice Waiver program in accordance with Michigan's waiver agreement, Department policy and its contract with the Department. (Exhibit A, pp 9-15; Testimony)

3. Appellant is a [redacted] year old Medicaid beneficiary, born July 23, 1991. (Exhibit 1; Testimony).

4. On [redacted], Appellant was transferred to [redacted] from his previous MI Choice Waiver Agency, the [redacted] for [redacted] Michigan. The previous Waiver Agency was going to be trimming back services and Appellant was given a choice of staying with them and having his services trimmed back, or transferring to [redacted]. (Exhibit A, p 2, 4-8; Testimony).

5. Appellant chose to transfer to [redacted] and the Waiver Agency honored Appellant's wishes to remain with the same hours of care that had been previously authorized (14 hours per day of PDN) and remain with the same service provider, [redacted], Inc. As such, [redacted] has continued to provide Appellant with 14 hours of PDN per day. (Exhibit A, p 2, 4-8; Testimony)

6. Over the past few months, Appellant's guardian began to request an increase in services. Specifically, Appellant's guardian requested PDN 24 hours per day 7 days per week or, in the alternative, the addition of Community Living Supports (CLS) and respite to the 14 hours of PDN Appellant was receiving. Appellant's guardian also requested that Appellant be given Home Help Services (HHS) through DHS in addition to his PDN, but Appellant's guardian expressed at the hearing that she understood that HHS had been terminated by Appellant's previous Waiver Agency because HHS was a duplicate of services received through the Waiver Agency. (Exhibit A, p 2, 4-8; Testimony)

7. Appellant's provider has informed the Waiver Agency that they are able to meet Appellant's needs within the 14 hours of PDN per day authorized. (Exhibit A, p 6; Testimony)

8. On [redacted], the Waiver Agency sent Appellant's guardian an Adequate Action Notice informing her that her request for CLS and respite was denied because respite cannot be provided in the home because of the medical acuity of Appellant's condition and that CLS is being provided by PDN during the 14 hours per day they are in the home. Appellant's guardian had previously been advised that the Waiver Agency cannot provide 24 hours of PDN per day. Appellant's guardian was also advised that respite could be provided outside of the home, just not in the home because respite workers did not have the skills necessary to meet Appellant's medical needs. (Exhibit A, pp 4-8; 21; Testimony)

9. On [redacted], the Michigan Administrative Hearing System received Appellant's request for hearing. (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.

This Appellant is claiming services through the Department's Home and Community Based Services for Elderly and Disabled (HCBS/ED). The waiver is called MI Choice in Michigan. The program is funded through the federal Centers for Medicare and Medicaid (formerly HCFA) to the Michigan Department of Community Health (Department). Regional agencies function as the Department's administrative agency.

> Waivers are intended to provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of recipients. Waivers allow exceptions to State plan requirements and permit a State to implement innovative programs or activities on a time-limited basis, and subject to specific safeguards for the protection of recipients and the program. Detailed rules for waivers are set forth in subpart B of part 431, subpart A of part 440 and subpart G of part 441 of this chapter. [*42 CFR 430.25(b)*].

A waiver under section 1915(c) of the [Social Security] Act allows a State to include as "medical assistance" under its plan, home and community based services furnished to recipients who would otherwise need inpatient care that is furnished in a hospital, SNF [Skilled Nursing Facility], ICF [Intermediate Care Facility], or ICF/MR [Intermediate Care Facility/Mentally Retarded], and is reimbursable under the State Plan. *42 CFR 430.25(c)(2)*.

Home and community based services means services not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this subchapter. 42 CFR 440.180(a).

> Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:
>
> - Case management services.
> - Homemaker services.
> - Home health aide services.
> - Personal care services.

- Adult day health services
- Habilitation services.
- Respite care services.
- Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.

Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization. 42 CFR 440.180(b).

The MI Choice Policy Chapter to the *Medicaid Provider Manual*, *MI Choice Waiver*, January 1, 2015, provides in part:

4.1 COVERED WAIVER SERVICES

In addition to regular State Plan coverage, MI Choice participants may receive services outlined in the following subsections. [p. 10].

* * *

4.1.P. PRIVATE DUTY NURSING

Private Duty Nursing (PDN) services are skilled nursing interventions provided to a participant age 21 and older on an individual and continuous basis to meet health needs directly related to the participant's physical disorder. 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 participant's plan of service. To be eligible for PDN services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III.

The participant's plan of service must provide reasonable assurance of participant safety. This includes a strategy for effective back-up in the event of an absence of providers. The back-up strategy must include informal supports or the participant's capacity to manage his/her care and summon assistance.

PDN for a participant between the ages of 18-21 is covered under the Medicaid State Plan.

Medical Criteria I – The participant is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

- Mechanical rate-dependent ventilation (four or more hours per day) or assisted rate dependent respiration (e.g., some models of bi-level positive airway pressure); or

- Deep oral (past the tonsils) 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 (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. 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 P02 level is 55 mm HG or below.

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) as a result of a substantiated medical condition directly related to the physical disorder.

Definitions of Medical Criteria II:

- "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 that 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 physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in three or more ADL.

- "Substantiated" means documented in the clinical or medical record, including the nursing notes.

Medical Criteria III – The participant requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

Definitions of Medical Criteria III:

- "Continuous" means at least once every three hours throughout a 24-hour period, and 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 participant 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 P02 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.

- Participants receiving MI Choice Nursing Services are not eligible to receive Private Duty Nursing services.

- Where applicable, the participant must use Medicaid State Plan, Medicare, or third party payers first.

- The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

- It is not the intent of the MI Choice program to provide PDN services on a continual 24-hours-per-day/7-days-per-week basis. MI Choice services are intended to supplement informal support services available to the participant. Only under extreme circumstances should 24/7 PDN be authorized for a participant. These circumstances must be clearly described in the participant's case record and approved by MDCH.

- 24/7 PDN services cannot be authorized for participants who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency back-up plan without assistance. These participants must have informal caregivers actively involved in providing some level of direct services to them on a routine basis.

- All PDN services authorized must be medically necessary as indicated through the MI Choice assessment and meet the medical criteria set forth in this chapter.

- The participant's physician, physician's assistant, or nurse practitioner must order PDN services and work in conjunction with the waiver agency and provider agency to assure services are delivered according to that order. Emphasis added.

Medicaid Provider Manual
MI Choice Waiver Chapter
January 1, 2015, pp 21-24

The Waiver Agency's Program Director testified that on [redacted], Appellant was transferred to [redacted] from his previous MI Choice Waiver Agency, the [redacted] for [redacted]. The Waiver Agency's Program Director indicated that the previous Waiver Agency was going to be trimming back services and Appellant was given a choice of staying with them and having his services trimmed back, or transferring to [redacted]. The Waiver Agency's Program Director testified that Appellant's mother/guardian chose to transfer to [redacted] and the Waiver Agency honored Appellant's wishes to remain with the same hours of care that had been previously authorized (14 hours per day of PDN) and remain with the same service provider, [redacted], Inc. As such, the Waiver Agency's Program Director indicated that they have continued to provide Appellant with 14 hours of PDN per day.

The Waiver Agency's Program Director further testified that over the past few months, Appellant's guardian began to request an increase in services. Specifically, Appellant's

guardian requested PDN 24 hours per day 7 days per week or, in the alternative, the addition of Community Living Supports (CLS) and respite to the 14 hours of PDN Appellant was receiving. Appellant's guardian also requested that Appellant be given Home Help Services (HHS) through DHS in addition to his PDN. The Waiver Agency's Program Director testified that the Waiver Agency reviewed Appellant's requests and notified Appellant's guardian on [redacted], that the request for CLS and respite were denied because respite cannot be provided in the home because of the medical acuity of Appellant's condition and that CLS is being provided by PDN during the 14 hours per day they are in the home. The Waiver Agency's Program Director indicated that Appellant's guardian had previously been advised that the Waiver Agency cannot provide 24 hours of PDN per day and that respite could be provided outside of the home, just not in the home because respite workers did not have the skills necessary to meet Appellant's medical needs. The Waiver Agency's Program Director also testified that Appellant's HHS was terminated when Appellant was with the prior Waiver Agency because it amounted to a duplication of services. Appellant's mother/ guardian indicated at the hearing that she understood this fact.

The Waiver Agency's Program Director also reviewed the applicable policy in support of its decision.

Appellant's mother/guardian testified that Appellant does require 24 hours of care. Appellant's mother/guardian indicated that both her and her husband are also disabled and cannot lift Appellant anymore. Appellant's mother/guardian testified that the family was also getting HHS in the past, but she indicated that she understood why the HHS was terminated. However, Appellant's mother/guardian pointed out that the nurses do not do the cleaning and laundry that the HHS workers used to do. Regarding respite, Appellant's mother/guardian questioned why Appellant should have to leave his home and his family, whom he has never been away from, for the parents to receive respite. Appellant's mother/guardian testified that she has paid family and friends to care for Appellant in her absence in the past, so certainly respite workers could be trained to do so. Regarding CLS, Appellant's mother/guardian testified that after the nurses get done with all of their work, there is little time left to take Appellant out into the community.

This ALJ finds that the Waiver Agency properly denied Appellant's request for 24/7 PDN services, respite in the home, and additional CLS. As indicated above, policy from the MPM prohibits 24/7 PDN except in the most extreme cases:

> It is not the intent of the MI Choice program to provide PDN services on a continual 24-hours-per-day/7-days-per-week basis. MI Choice services are intended to supplement informal support services available to the participant. Only under extreme circumstances should 24/7 PDN be authorized for a participant. These circumstances must be clearly described in the participant's case record and approved by MDCH.

Here, there are no extreme circumstances. Appellant's provider has informed the Waiver Agency that they are able to meet Appellant's needs within the 14 hours of PDN per day authorized. Appellant has informal supports that have, and continue, to care for him during the 10 hours per day PDN services are not in the home. And, Appellant's mother/guardian indicated that the family has been able to find and utilize other informal supports to care for Appellant when she and her husband are absent.

With regard to respite, Appellant has not been denied respite; he has simply been denied the delivery of respite in the home because his condition requires a level of care that exceeds the capabilities of in-home respite workers. Appellant is free to take advantage of respite in a facility if he so desires. Generally, a disagreement about the location where services are offered does not give rise to a Medicaid fair hearing because such a disagreement does not amount to a "denial, reduction, suspension, or termination of a requested or previously authorized Medicaid covered service", as outlined in the Code of Federal Regulations. (*See 42 CFR 438.400*).

Finally, the Waiver Agency is correct that CLS is included in the 14 hours per day of CLS Appellant receives. The PDN provider has agreed that the nurses are able and willing to take Appellant out into the community and they should have sufficient time to do so with 14 hours per day of PDN. Appellant's mother/guardian even admitted at the hearing that Appellant's daily direct care takes the nurses about 8 hours per day, which would leave 6 hours per day for community activities.

Accordingly, Appellant has failed to meet his burden of showing by a preponderance of the evidence that he should receive 24/7 PDN services, respite in the home, and additional CLS.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, this Administrative Law Judge finds the Waiver Agency properly denied Appellant's request for 24/7 PDN services, respite in the home, and additional CLS.

IT IS THEREFORE ORDERED that:

The MI Choice Waiver Agency's decision is AFFIRMED.

Robert J. Meade
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

cc: [redacted]

RJM[redacted]

Date Signed: [redacted]

Date Mailed: [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.