[redacted]
MI [redacted]

Date Mailed: July 14, 2022
MOAHR Docket No.: 22-002375
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on July 12, 2022. [redacted], Petitioner's Father and Guardian, appeared on behalf of Petitioner. [redacted], R.N., appeared as a witness for Petitioner.

Kim Motter, Director of Quality, appeared on behalf of Respondent, Reliance Community Care (Department).

Exhibits:

Petitioner	None
Department	A. Hearing Summary

ISSUE

Did the Department properly deny Petitioner's request for additional 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 Department contracts with the Waiver Agency to provide MI Choice Waiver services to eligible beneficiaries.

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.

3. Petitioner is Medicaid beneficiary, who has a medical history of hereditary sensory and autonomic neuropathy movement disorder, developmental delay, GERD, iron deficiency anemia, seasonal allergies, scoliosis, sleep apnea, asthma, multiple wounds, chronic diarrhea, urinary and bowel incontinence and a history of multiple fractures. (Exhibit A, p 4; Testimony.)

4. Since at least 2014, Petitioner has received services from Department and has been approved for PDN to treat Petitioner's wounds. (Testimony.)

5. At all times relevant to this proceeding, the Department has provided nursing services to Petitioner in conjunction with benefits provided by an Office of Community Mental Health. The Office of Community Mental Health provided CLS services and Behavioral services. (Testimony.)

6. From 2014 to current, Petitioner's wound care has not changed. (Exhibit A, p 3; Testimony.)

7. At all times relevant to this proceeding, Petitioner's wound stages have varied from 1-3. (Exhibit A, p 3; Testimony.)

8. From 2014 up through May 24, 2022, Petitioner had been approved for and received PDN in the amount of 7 hours per day. (Exhibit A, pp 4, 19; Testimony.)

9. On May 24, 2022, Petitioner requested an increase of 5 hours per day of PDN for a total of 12 PDN a day. (Exhibit A, p 19; Testimony.)

10. On or around May 24, 2022, the Department denied Petitioner's request for additional PDN. (Exhibit A, pp 3; 19; Testimony.)

11. On June 1, 2022, the Michigan Office of Administrative Hearings and Rules, received from Petitioner a request for hearing.

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.

Here, Petitioner 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 Health and Human Services (MDHHS). 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.[1]

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.[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.[3]

According to 42 CFR 440.180(b), 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.

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[1] *42 CFR 430.25(b)*.
[2] *42 CFR 430.25(c)(2)*.
[3] 42 CFR 440.180(a).

- Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.

The MI Choice Policy Chapter in the *Medicaid Provider Manual*, *MI Choice Waiver*, provides in pertinent part:

> **4.1 COVERED WAIVER SERVICES**
>
> In addition to regular State Plan coverage, MI Choice participants may receive services outlined in the following subsections.
>
> * * *
>
> **4.1.M. 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.[4]

The Department in this matter indicated the decision to deny Petitioner's request was based on the fact Petitioner's wounds have not worsened or increased in severity since he began receiving services in 2014. The Department went on to indicate that Petitioner's needs could be better treated via additional CLS or Behavioral services and that at this time, additional skilled nursing services are not medically necessary.

Petitioner did not offer much in response to the Department's arguments. Specifically, Petitioner did not appear to dispute the fact the wounds have not changed much since 2014 or provide any evidence of additional PDN being medically necessary. Petitioner also did not offer much of an explanation as to why additional CLS or Behavioral services would be better suited to treat Petitioner's current needs. Although Petitioner is currently experiencing an issue with staff turnover, this is not a justification for additional PDN.

Based on the evidence presented, I find sufficient evidence to affirm the Department's decision to deny additional PDN services. If Petitioner's conditions worsen/deteriorates, Petitioner can always make a new request for additional PDN.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly determined that Petitioner was not eligible for additional PDN services.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

CA/dh

Corey Arendt
Administrative Law Judge

[4] Medicaid Provider Manual, MI Choice Waiver Chapter, April 1, 2022, pp 18, 40-43.

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

Via Electronic Mail:

Community Health Rep.
Reliance Community Care Partners
2100 Raybrook St. SE, #203
Grand Rapids, MI 49546
Kim.Motter@relianceccp.org

DHHS Department Rep.
Elizabeth Gallagher
400 S. Pine
Lansing, MI 48909
GallagherE@michigan.gov

Via First Class Mail:

Petitioner
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