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],

Appellant

/

Docket No. 2012-71236 PAC
2013-38865 REH

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 the Appellant's request for a hearing.

After due notice, a rehearing was held on [redacted]. The Appellant was represented by his mother, [redacted]. She had no witnesses. [redacted], Appeals Review Officer, represented the represented the Department. Her witness was [redacted], R.N., Program Review Division, Michigan Department of Community Health.

ISSUE

Did the Department properly deny Appellant's request for prior authorization (PA) of 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 Appellant is a [redacted] year-old Medicaid beneficiary. (Appellant's Exhibit 1)

2. The Appellant is afflicted with Pierre Robin Syndrome, Charge-like syndrome, aorta stenosis, glossoptosis, bilateral congenital vertical tali, progressive high myopia, dysplasia, severe DD. He has recently recovered from pneumonia. He has a tracheotomy with a GJ tube in place. (Department's Exhibit A, p. 98 and *See* Testimony throughout).

3. The Appellant was reapproved, by PA, for eight (8) hours of PDN on [redacted] and [redacted]. (Departments Exhibit A, pp. 20, 21 57)

4. On [redacted] and [redacted] the Appellant, by PA, sought additional PDN over and above the authorized eight (8) hours. (Department's Exhibit A, pp. 81 – 91)

5. Request(s) for additional information were submitted to the Appellant and his providers on [redacted], [redacted] and [redacted]. (Department's Exhibit A, pp. 22, 55,56 and 60)

6. The Department reviewed the submitted documentation and found it insufficient to establish medical necessity for a higher level of care via increased PDN [increased hours]. However, the Department acknowledged a seasonal adjustment in PDN hours on a "Fall/Winter" exacerbation of symptoms. (Department's Exhibit A – throughout and See Testimony of [redacted], R.N.).

7. The Department notified the Appellant of his denial, in writing, on [redacted] explaining further that the decision was reached under the exception process of the Medicaid Provider Manual (MPM) at section 2.5 Private Duty Nursing [chapter]. (Department's Exhibit A, pp. 139 and 140)

8. The Appellant's further appeal rights were contained therein. (Department's Exhibit A, pp. 139, 140)

9. On [redacted] the instant appeal was received by the Michigan Administrative Hearing System (MAHS) for the Michigan Department of Community Health (MDCH). It was assigned for hearing on [redacted] and continued to [redacted]. The case was dismissed on Appellant's failure to appear for hearing on [redacted]. On Appellant's request for reconsideration the order of dismissal was vacated and the case reassigned to ALJ Malewska for rehearing on [redacted].

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.

It is axiomatic that the Medicaid program exists to ensure that medically necessary services and equipment are made available to those who would not otherwise have the resources to purchase them. It is also fundamental that Medicaid is payor of last resort. Private duty nursing (PDN) is a Medicaid benefit when provided in accordance with the policies and procedures outlined in the Medicaid Provider Manual (MPM) which provides, in pertinent part, as follows:

[ ] – GENERAL INFORMATION [PRIVATE DUTY NURSING]

This chapter applies to Independent and Agency Private Duty Nurses.

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.

****

[ ] DEFINITION OF PDN

Private Duty Nursing is defined as nursing services for beneficiaries who require more individual and continuous care, in contrast to part-time or intermittent care, than is available under the home health benefit. These services are provided by a registered nurse (RN), or licensed practical nurse (LPN) under the supervision of an RN, and must be ordered by the beneficiary's physician. Beneficiaries requiring PDN must demonstrate a need for continuous skilled nursing services, rather than a need for intermittent skilled nursing, personal care, and/or Home Help services. The terms "continuous" and "skilled nursing" are further defined in the Medical Criteria subsection for beneficiaries under age 21.

****

The MSA-0732 must be submitted every time services are requested for the following situations:

- for initial services when the beneficiary has never received PDN services under Medicaid, such as following a hospitalization or when there is an increase in severity of an acute or chronic condition;
- for continuation of services beyond the end date of the current authorization period (renewal);
- for an increase in services; or
- for a decrease in services.

Following receipt and review of the MSA-0732 and the required documentation by the Program Review Division, a Notice of Authorization is sent to the PDN provider and beneficiary or primary caregiver, either approving or denying services, or requesting additional information. The provider must maintain this notice in the beneficiary's medical record. For services that are approved, the Notice of Authorization will contain the prior authorization number and approved authorization dates. It is important to include this PA number on every claim and in all other communications to the Program Review Division.

If a beneficiary receiving PDN continues to require the services after the initial authorization period, a new MSA-0732 must be submitted along with the required documentation supporting the continued need for PDN. This request must be received by the Program Review Division no less than 15 business days prior to the end of the current authorization period. Failure to do so may result in a delay of authorization for continued services which, in turn, may result in delayed or no payment for services rendered without authorization. The length of each subsequent authorization period will be determined by the Program Review Division and will be specific to each beneficiary based on several factors, including the beneficiary's medical needs and family situation.

If during an authorization period a beneficiary's condition changes warranting an increase or decrease in the number of approved hours or a discontinuation of services, the provider must report the change to the Program Review Division.[1]

****

[1] *See* MPM at §2.6 Change in [ ] Condition/PDN as transitional benefit. *Supra*

[ ] – CARE REQUIREMENTS

A written plan of care (POC) guides all services provided to the beneficiary by the PDN provider. The POC identifies and addresses the beneficiary's need for PDN. The POC and the process for developing it reflect the beneficiary's and family's basic rights of self-determination and autonomy.

- ●Family members and the beneficiary (as appropriate to his maturity) participate in developing the POC. They are provided with accurate information and support appropriate to informed decision making; and they must give informed consent for planned services.
- ● Beneficiary/family strengths, including cultural and ethnic identity, are respected and utilized in the delivery of care. Services delivered in the home accommodate beneficiary/family life activities.
- ● The plan includes goals directed toward increasing beneficiary/family capability, effectiveness, and control.
- ● The plan includes compensatory services to support the growth and developmental potential of each beneficiary, given his disability or illness.
- ● Appointments are coordinated and services are scheduled with the goals of minimizing inconvenience to the beneficiary/family, and of facilitating the family's participation in the beneficiary's care.
- ●If the services are provided by LPNs, the POC must identify the frequency of the supervisory RN visits.

The written POC must be retained in the beneficiary's medical record.

****

[2.3] MEDICAL CRITERIA

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 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, 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, (MPM)
Private Duty Nursing April 1, 2012

****

2.4 DETERMINING INTENSITY OF CARE AND MAXIMUM AMOUNT OF PDN

As part of determining the maximum amount of PDN a beneficiary is eligible for, his Intensity of Care category must be determined. This is a clinical judgment based on the following factors:

- The beneficiary's medical condition;
- The type and frequency of needed nursing assessments, judgments and interventions; and
- The impact of delayed nursing interventions.

Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary, but do not determine the number of hours of nursing for which the beneficiary is eligible.

High Category Medium Category Low Category

Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition.

Medium Category Low Category

Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least 1 time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.

Low Category

Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.

Medicaid uses the "Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis" (below) to establish the amount of PDN that is approved. The Decision Guide is used to determine the appropriate range of nursing hours that can be authorized under the Medicaid PDN benefit and defines the "benefit limitation" for individual beneficiaries. The Decision Guide Michigan Department of Community Health Medicaid Provider Manual is used by the authorizing entity after it has determined the beneficiary meets both general eligibility requirements and medical criteria as stated above. The amount of PDN (i.e., the number of hours) that can be authorized for a beneficiary is based on several factors, including the beneficiary's care needs which establish medical necessity for PDN, the beneficiary's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts, bequests, private pay). To illustrate, the number of hours covered by private health insurance is subtracted from the hours approved under Medicaid PDN. These factors are incorporated into the Decision Guide. The higher number in the range is considered the maximum number of hours that can be authorized. Except in emergency circumstances, Medicaid does not approve more than the maximum hours indicated in the guide.

Only those factors that influence the maximum number of hours that can be authorized are included on this decision matrix. Other factors (e.g., additional dependent children, additional children with special needs, and required nighttime interventions) that impact the caregiver's availability to provide care should be identified during an assessment of service needs. These factors have implications for service planning and should be considered when determining the actual number of hours (within the range) to authorize.

Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis

FAMILY SITUATION/ RESOURCE CONSIDERATIONS		INTENSITY OF CARE Average Number of Hours Per Day		
		LOW	**MEDIUM**	**HIGH**
Factor I – Availability of Caregivers Living in the Home	2 or more caregivers; both work or are in school F/T or P/T	4-8	6-12	10-16
	2 or more caregivers; 1 works or is in school F/T or P/T	4-6	4-10	10-14
	2 or more caregivers; neither works or is in school at least P/T	1-4	4-8	6-12
	1 caregiver; works or is in school F/T or P/T	4-8	6-12	10-16
	1 caregiver; does not work or is not a student	1-4	6-10	8-14
Factor II – Health Status of Caregiver(s)	Significant health issues	Add 2 hours if Factor I <= 8	Add 2 hours if Factor I <= 12	Add 2 hours if Factor I <= 14
	Some health issues	Add 1 hour if Factor I <= 7	Add 1 hour if Factor I <= 9	Add 1 hour if Factor I <= 13
Factor III – School *	Beneficiary attends school 25 or more hours per week, on average	Maximum of 6 hours per day	Maximum of 8 hours per day	Maximum of 12 hours per day

* Factor III limits the maximum number of hours which can be authorized for a beneficiary:

- Of any age in a center-based school program for more than 25 hours per week; or
- Age six and older for whom there is no medical justification for a homebound school program.
-

In both cases, the lesser of the maximum "allowable" for Factors I and II, or the maximum specified for Factor III, applies.

[2.5] EXCEPTION PROCESS

Because each beneficiary and his family are unique and because special circumstances arise, it is important to maintain an exception process to ensure the beneficiary's safety and quality of care. PDN services that exceed the beneficiary's benefit limitation, as established by the Decision Guide, must be prior authorized by the appropriate Medicaid case management program. Limited authority to exceed the published PDN benefit limitations may be granted on a time-limited basis as detailed below. The beneficiary or his primary care giver must initiate the request for an exception. The applicable Medicaid case management program's representative is responsible for facilitating the request and documenting the necessity for an exception. Factors underlying the need for additional PDN must be identified in the beneficiary's POC, which must include strategies directed toward resolving the factors

necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception;
- Current lack of natural supports required for the provision of the needed level of support; and
- Additional PDN services are essential to the successful implementation of the beneficiary's written plan of care, and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his condition.

Exceptions are time-limited and must reflect the increased identified needs of the beneficiary. Consideration for an exception is limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

A temporary alteration in the beneficiary's care needs following a hospitalization, resulting in one or both of the following:

- A temporary increase in the intensity of required assessments, judgments, and interventions.
- A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs.

The total number of additional PDN hours cannot exceed two hours per day, for a maximum of six months.

The temporary inability of the primary caregiver(s) to provide required care as the result of one of the following:

("Inability" is defined as the caregiver is either unable to provide care or is prevented from providing care.)

- An acute illness or injury of the primary caregiver(s). The total number of additional PDN hours cannot exceed two hours per day for the duration of the caregiver's inability, not to exceed six months. In the event there is only one caregiver living in the home and that caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized.
- The death of the primary caregiver(s) or an immediate family member. "Immediate family member" is defined as the

> caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days.
> ☐ The home environment has been determined to be unstable, as evidenced by DHS protective or preventive services involvement.
>
> The written POC and community-based care coordination activities must include strategies directed toward stabilizing service supports and/or the family situation. The maximum number of hours varies by the beneficiary's Intensity of Care category: High = maximum of 18 hours per day; Medium = maximum of 14 hours per day; Low = maximum of 10 hours per day. The length of time for this exception is three months or the time needed to stabilize service supports and/or family situation, whichever is less. A one-time extension of up to three months may be made if there is documented progress toward achieving the stabilized home environment.
>
> MPM, Private Duty Nursing,
> §§1 through 2.5, pp. 1 -13, April 1, 2012

***

In this case, there was no dispute that the Appellant is a beneficiary under 21 years of age who meets the criteria for PDN as one who requires continuous care – as opposed to part time or intermittent skilled nursing care.

The instant appeal for resolution today, under the exception provisions of the MPM, is: how much?

Basically, the Department witness [redacted] states that while there is adequate documentation to support the idea that the Appellant requires 8 hours of PDN, there was insufficient evidence to establish or support for the desired 12 hours of PDN for the Appellant [or his caregivers].

The Appellant's representative acknowledged that the nursing agency failed to respond fully to the Department's requests for additional information. She said that the process was "… subjective"[2] and that the attendant concentration of duties within an 8 hour limit forces medication errors or other mistakes or omissions to occur. She said it was a "health and safety" issue – that required additional hours to properly address.

In her petition, but not her testimony, the Appellant's representative stated that the Appellant's father has left the home causing the Appellant's representative to function

[2] It was so acknowledged by [redacted] in her testimony.

as a single mother. How – or whether that translated into the provision of services was not addressed by the Appellant's representative at hearing.

The Appellant's representative argued that the Appellant's physican has recommended 12 hours of PDN and that the Appellant requires a significant amount of suctioning during the evening as to justify the additional skilled hours of service.

The Department witness testified that she observed and noted the additional suctioning tasks documented in the nursing notes and acquiesced in the physician's letter found at page 98 of the Department's Exhibit – however she said nothing was presented that justified a permanent increase in PDN from 8 to 12 hours.

The Department's witness said that evidence of additional hospitalizations and evidence of the Appellant's having difficulty breathing – with supporting documentation would have merited additional review – but this information was simply not presented.

On review, the Appellant is, at this point in his young life, a victim of his own success. He was treated and released to home based care following his hospitalization. Additional suction was temporarily needed. Additional hours are available for the Appellant in the acute, but not the chronic. According to the documentation produced and reviewed by the [redacted] – the Appellant was stable**.**

The Department's witness, [redacted], as grantor of the PDN exception is responsible for evaluating the documentation purporting to demonstrate a medical necessity exception or lack of natural supports. *See* MPM at §2.5 *Supra*

With only one hospitalization and a moderate demonstration of increased suctioning necessitated by a temporary upper respiratory illness - her conclusion that the Appellant did not merit increased PDN hours or an adjustment from medium ranking nursing care or increased intensity of care was properly supported in the record.

In light of the safeguard of a potential seasonal adjustment[3] and the MPM exception process itself the Department properly denied the Appellant's request for additional private duty nursing hours – over and above eight (8) hours.

The Appellant failed to preponderate his burden of proof.

[3] As submitted - temporary seasonal increase in PDN available during the Fall/Winter months. *See* Department's Exhibit A. p. 139

All Prior Authorization for PDN or exceptions therefrom must be supported by appropriate medical documentation and be completed by the referring physician or appropriate subspecialist. The Appellant failed to establish that he met the criteria for exception in this case - most notably for lack of medical necessity as opposed to lack of natural supports.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Appellant's request for additional PDN hours.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

[redacted]

cc: [redacted]

Date Signed: 8/12/2013

Date Mailed: 8/12/2013

***** 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.