STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 15-008102-CMH
Case No. [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 a request for hearing filed on Appellant's behalf.

After due notice, a hearing was held on July 21, 2015. [redacted], Appellant's mother and guardian, appeared and testified on Appellant's behalf. Attorney [redacted] Ottawa County Corporate Counsel, represented Community Mental Health of Ottawa County (CMH, Department or Respondent). [redacted], Fair Hearing Officer; [redacted], Supports Coordinator Supervisor; and [redacted], Director of Medical Services, appeared as witnesses for the Department.

ISSUE

Did the Department properly reduce Appellant's private duty nursing (PDN) services?

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] Medicaid beneficiary, born [redacted] who is enrolled in the Habilitation Supports Waiver Program through CMH. (Exhibit E, p 3; Testimony)

2. Appellant has been diagnosed with significant developmental delays and health conditions that include hydrocephalus, chronic lung disease, neurogenic bladder, reflux, sleep apnea, chronic kidney disease, and a history or urinary tract infections. (Exhibit E, p 3; Testimony)

3. Appellant is currently authorized to receive the following services through CMH: group home trainings, physical therapy initial evaluation, occupational therapy initial evaluation, wheelchair management, treatment planning, treatment monitoring, nursing care in the home (private duty nursing), and supports coordination. (Exhibit E, pp 5-6; Testimony)

4. Appellant is cared for in the homes of both of her parents with a schedule of alternating months. Appellant's parents advocate for her needs. Appellant can

participate in some personal care tasks with supports (like lifting her arms for dressing and making daily choices for favored activities). Appellant has good receptive language, can understand some simple requests and can communicate many of her wants and needs through informal and non-verbal means. (Exhibit E, p 3; Testimony)

5. Appellant is currently not attending school, at the recommendation of her doctor, but does receive special education services at home through Homebound services. (Exhibit E, p 3; Testimony)

6. On [redacted], Appellant underwent an annual reassessment to determine the medically necessary level of care for continued Private Duty Nursing (PDN). Following the reassessment, it was determined that Appellant's PDN needs had decreased over the previous year and she was found to be eligible for a Low Level Category of Care, which equates to 4-8 PDN hours per day. Appellant was authorized to receive 8 PDN hours per day, 7 days per week, which was a decrease from the 10 PDN hours per day Appellant had received during the previous period. (Exhibit A, pp 1-6; Exhibits B, C, D; Testimony)

7. The PDN evaluation was based in part on PDN service logs supplied by St. John's Health Care, the contractual provider of PDN services to Appellant. Those logs show that between January 1, 2015 and April 14, 2015 (103 days), Appellant required deep suctioning 226 times, for an average of 2.19 interventions per day. The daily amount of deep suctioning ranged from 1 time per day to 5 times per day. On 73 out of the 103 days considered, Appellant required suctioning only 1 or 2 times. (Exhibit D; Testimony)

8. Since 2011, Appellant's PDN services have been allocated as follows:

    - 2011 Low Level Category of Care
    - 2012 Low Level Category of Care
    - 2013 Low Level Category of Care
    - 2014 Medium Level Category of Care
    - 2015 Low Level Category of Care

    (Testimony)

9. While not directly applicable to persons over age 21 receiving PDN through the Habilitation Supports Waiver, the MPM does provide a Decision Guide for determining the amount of PDN for children under 21 years of age. The Department has informed CMH's that they may use the Decision Guide as a reference when determining the amount of PDN to authorize under the Habilitation Supports Waiver for those over age 21. (Testimony)

10. On [redacted], an Adequate Notice of Rights and Appellant's Individual Plan of Service, outlining the reduction in PDN, were mailed to Appellant's guardians. (Exhibit E; Testimony)

11. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on Appellant's behalf. (Exhibit 1; Testimony)

12. On [redacted], a Local Appeal was conducted by the CMH and the decision to reduce PDN was upheld. (Exhibit F; Testimony)

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…

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

Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. *See 42 CFR 440.230.*

Medicaid policy in Michigan is contained in the Medicaid Provider Manual (MPM), which provides, in pertinent part:

SECTION 2 – PROGRAM REQUIREMENTS

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2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:
    - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
    - that are experimental or investigational in nature; or
    - for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or

- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent

utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

Medicaid Provider Manual
Mental Health/Substance Abuse Chapter
April 1, 2015, pp 12-14

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.

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15.1 WAIVER SUPPORTS AND SERVICES

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Private Duty Nursing (PDN)

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

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.

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Once the Medical Criteria eligibility for PDN has been established, and as part of determining the amount of PDN a beneficiary is eligible for, the 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 amount of hours of nursing for which the beneficiary is eligible.

High 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, death, or in acceleration of the chronic condition.

Medium 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 one 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, 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.

The amount of PDN hours authorized represents a monthly total determined by calculating an average amount of PDN per day multiplied by the number of days in the month. The beneficiary has the flexibility to use the hours as needed during the month, not to exceed the total monthly authorized amount.

The amount of PDN (i.e., the number of hours that can be authorized for a beneficiary) is determined through the person-centered planning process to address the individual's unique needs and circumstances. Factors to be considered should include the beneficiary's care needs which establish medical necessity for PDN; the beneficiary's and family's circumstances (e.g., the availability of natural supports); and other resources for daily care (e.g., private health insurance, trusts, bequests). Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, a beneficiary who has Low Category PDN needs would require eight or fewer hours per day, a beneficiary who has Medium Category PDN needs would require 12 or fewer hours per day, and a beneficiary who has High Category PDN needs would require 16 or fewer hours per day.

The nurse may provide personal care only when incidental to the delivery of PDN, e.g., diaper changes, but may not provide routine personal care. The provision of personal care in unlicensed homes is through Home Help, a state plan service. If the beneficiary receiving PDN services demonstrates the need for Home Help services, the IPOS must document coordination of Home Help and PDN to assure no duplication of services.

Licensed nurses provide the nursing treatments, observation, and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services.

These services should be provided to a beneficiary at home or in the community. A physician's prescription is required.

The PIHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Champus, Worker's Compensation, an indemnity policy, automobile insurance) for private duty nursing and will assist the beneficiary in selecting a private duty nursing provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary.

If a beneficiary is attending school and the Individualized Educational Plan (IEP) identifies the need for PDN during transportation to and from school and/or in the classroom, the school is responsible for providing PDN during school hours. For adults up to age 26 who are enrolled in school, PDN services are not intended to supplant services provided in school or other settings or to be provided during the

times when the beneficiary would typically be in school but for the parent's choice to home-school.

An exception process to ensure the beneficiary's health, safety and welfare is available if the beneficiary's needs exceed the 16-hours-per-day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the beneficiary's plan, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception; 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 must be based on the increased identified medical needs of the beneficiary or the impact on the beneficiary's needs due to the unavailability of the primary unpaid caregiver. 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, 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 per day will be based on the physician's documentation of the extent and duration of the beneficiary's increased medical needs for a maximum of six months.

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

    - In the event the caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital, or in the event of an acute illness or injury of the caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the caregiver's limitations and the needs of the beneficiary as it relates to those limitations, not to exceed six months.

- The death of the primary caregiver. The initial amount of hours allowable under this exception is 24 hours per day for 14 days. Subsequent exceptions can be approved up to an additional 60 days, with monthly reviews thereafter by the PIHP/CMHSP.

- The death of 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.

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

"Primary caregiver" is defined as the caregiver who provides the majority of unpaid care.

"Unpaid care" is defined as care provided by a caregiver where no reimbursement is received for those services, e.g., is not being paid as a Home Help provider or Community Living Supports staff.

This exception is not available if the beneficiary resides in a licensed setting or in a home where all care is provided by paid caregivers.

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.

Medicaid Provider Manual
Mental Health/Substance Abuse Chapter
April 1, 2015, pp 96, 105, 108-111
Emphasis added.

While not directly applicable to persons over age 21 receiving PDN through the Habilitation Supports Waiver, the MPM does provide a Decision Guide for determining the amount of PDN for children under 21 years of age. The Department has informed CMH's that they may use the Decision Guide as a reference when determining the amount of PDN to authorize under the Habilitation Supports Waiver, although the actual determination needs to be made through the Person Centered Planning Process and the policy outlined above.

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	6-12	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.

Medicaid Provider Manual
Private Duty Nursing Chapter
April 1, 2015 pp. 11-12

CMH's Fair Hearing Officer testified that she has a Master's Degree in Social Work, has worked for CMH for 15 years and as a Fair Hearing Officer for 7 years. CMH's Fair Hearing Officer reviewed Exhibit A, the PDN Eligibility Determination Worksheet, and indicated that the Michigan Department of Health and Human Services (MDHHS) requires the CMH to use that form when determining eligibility for PDN services and the amount of those PDN services. CMH's Fair Hearing Officer testified that Appellant receives CMH services through the Habilitation Supports Waiver as a person over aged 21. CMH's Fair Hearing Officer indicated that she has spoken to MDHHS representatives, who have informed her that the PDN Decision Guide for persons under aged 21 receiving PDN can be used as a reference when making determinations about the amount of PDN to authorize for persons over age 21, like Appellant. CMH's Fair Hearing Officer reviewed the Decision Guide, found in Exhibit B, as well as policy relating to PDN found in the MPM, found in Exhibit C. CMH's Fair Hearing Officer reviewed Exhibit D, the nursing logs the evaluator relied on when making her decision to reduce Appellant's PDN, and pointed out that the determination made was consistent with the number of nursing interventions documented on those logs. CMH's Fair Hearing Officer reviewed the Adequate Notice sent to Appellant following the decision, as well as Appellant's Individualized Plan of Services, found in Exhibits E and F respectively. CMH's Fair Hearing Officer also

reviewed the relevant portions of the Michigan Mental Health Code, found in Exhibit G and the CMH's contract with the MDHHS, found in Exhibit H.

CMH's Director of Medical Services testified that she is an RN, certified in psychiatry and mental health, and has worked for CMH for 24 years. CMH's Director of Medical Services indicated that she supervises all RN's at her agency, supervises the person who conducted the PDN evaluation here, and has completed PDN training provided by MDHHS. CMH's Director of Medical Services noted that the RN who conducted Appellant's PDN evaluation is the same RN who has conducted Appellant's PDN evaluations since 2009. CMH's Director of Medical Services noted that Appellant did have increased hospitalizations and need for suctioning in 2014, so she was moved up to the Medium Level Category of Care for PDN. However, CMH's Director of Medical Services noted that in 2015, Appellant's needs decreased, so it was appropriate to move her back to the Low Level Category of Care for PDN. CMH's Director of Medical Services testified that following a hospitalization in 2014, Appellant also had a tracheotomy placed, which decreases the change of incidents of infection. CMH's Director of Medical Services indicated that she too reviewed all of the records the RN evaluator based her decision on and agreed with the decision to reduce Appellant's PDN. CMH's Director of Medical Services also noted that the PDN Decision Guide does not control now that Appellant is over age 21, but that the MDHHS has informed them that they can use the Guide as a reference. CMH's Director of Medical Services testified that it is not unusual for someone in Appellant's position to improve over time and that the recommended level of care here was appropriate to meet Appellant's needs.

CMH's Supports Coordinator Supervisor testified that she has worked for CMH for 15 years and supervises all of the Supports Coordinators who work with persons with developmental disabilities and persons who receive services under the Habilitation Supports Waiver. CMH's Supports Coordinator Supervisor indicated that she does weekly case consults with Appellant's Supports Coordinator, so is very familiar with Appellant's case. CMH's Supports Coordinator Supervisor testified that she also reviews PDN evaluations and has reviewed the PDN evaluation conducted here for Appellant. CMH's Supports Coordinator Supervisor reviewed the Exhibits filed in this matter. CMH's Supports Coordinator Supervisor indicated that the Person Centered Planning process is used to determine the amount of PDN authorized for persons in Appellant's position and that the PDN Decision Guide is just used as a reference. CMH's Supports Coordinator Supervisor pointed out that while Appellant was found to be in the Low Level Category of Care for PDN, she is receiving the maximum amount of PDN for persons in the Low Level (8 hours per day). CMH's Supports Coordinator Supervisor opined that upon her review of Appellant's records, the reduction in PDN was appropriate. CMH's Supports Coordinator Supervisor testified that Appellant also has the option of returning to school, until age 26, and that the school has three RN's and an LPN on staff who would be able to meet Appellant's needs during school hours. CMH's Supports Coordinator Supervisor testified that if Appellant returned to school, it would not affect the 8 hours of PDN she receives at home through CMH. CMH's Supports Coordinator Supervisor also testified that should Appellant have a crisis, her PDN can be increased after an assessment is completed. Finally, CMH's Supports Coordinator Supervisor testified that Appellant was continued at 10 PDN hours per day during the pendency of this appeal.

Appellant's mother questioned why more current PDN logs were not used in the determination

given that earlier logs were not completed accurately with the number of times Appellant required deep suctioning each day. CMH's Fair Hearing Officer responded that the RN's began tracking the number of suctioning each day back in February 2015, so the RN evaluator had at least two months of logs when the determination was made in April 2015. Appellant's mother testified that she had requested a second evaluation based on log discrepancies, but that another evaluation had not been done.

Appellant's mother indicated that Appellant has been hospitalized in the past a lot for pneumonia and that she had to have a tracheotomy inserted after a hospitalization in 2014. Appellant's mother indicated that Appellant has been kept home from school since that 2014 hospitalization per instructions from her doctor. Appellant's mother testified that Appellant takes a significant amount of medications and antibiotics and also receives breathing treatments from the RN's, which she and her husband cannot perform. Appellant's mother indicated that both she and Appellant's father work full-time, so it is difficult to work a full eight hour day with only eight hours per day of PDN. Appellant's mother pointed out that Appellant was receiving up to 12 hours of PDN per day before she turned 18 when she was receiving respite, but there has been no respite since Appellant turned 18 and it has been very difficult. Appellant's mother also testified that she has health issues which interfere with her ability to provide care for Appellant, but she indicated that she did not inform the RN evaluator of this fact during the evaluation because she was not asked. Appellant's mother also questioned whether she could get Appellant's PDN increased if there was a crisis because it took the evaluator a month to come out and do the PDN evaluation after Appellant came home from the hospital in January 2015. Appellant's mother testified that Appellant's health is always changing, although she did admit that Appellant's health has improved since 2014.

Based upon the evidence submitted, the Department properly determined that a reduction in Appellant's PDN was warranted. Appellant has failed to prove, by a preponderance of the evidence that the Department erred in authorizing a reduction in her PDN services. Clearly, Appellant has very significant health issues, requires an enormous amount of care and Appellant's family should be commended for the constant care that they provide to their daughter. However, based on policy, it is clear that Appellant now falls into the Low Level Category of Care for PDN. During the period in question, Appellant required, on average, 2.19 nursing interventions per day, which clearly falls into the Low Category. Again, the Low Level Category of Care for PDN equates to 4-12 assessments, judgments, and interventions per 12 hours shift. Furthermore, Appellant has been in the Low Category for four out of the last five years and Appellant's mother admitted that Appellant's condition has improved since 2014. The same RN has conducted Appellant's PDN evaluations since 2009, so she is intimately familiar with Appellant's needs. The RN evaluator has been trained in conducting PDN evaluations by the MDHHS, as has her supervisor, and the supervisor concurred that the reduction was appropriate. While Appellant's mother claims that the RN's were not properly completing the nursing logs when Appellant first returned from the hospital, the evidence shows that the RN's were properly completing the logs as of February 2015. As such, the RN evaluator had over two months of logs to consider when making her decision. Also, as indicated above, should Appellant's condition worsen, or should she have a crisis, her PDN can be increased temporarily. Appellant's mother was also advised during the hearing that the undersigned can only base his decision on information the CMH had when it issued its Adequate Notice of Rights on May 21, 2015.

According to the information submitted, the Department's reduction of Appellant's PDN from 10 to 8 hours per day must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly authorized a reduction in Appellant's PDN from 10 to 8 hours per day, based on the evidence submitted.

IT IS THEREFORE ORDERED THAT:

Respondent's decision is AFFIRMED.

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

Date Signed: [redacted]

Date Mailed: [redacted]

[redacted]

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System for the Department of Health and Human Services 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 Health and Human Services 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.