STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 15-012658 PAC

[redacted] [redacted] [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.*, and upon a request for a hearing filed on behalf of the minor Appellant.

After due notice, a telephone hearing was held on [redacted] Appellant's mother, appeared and testified on Appellant's behalf. [redacted] Appeals Review Officer, represented the Department of Health and Human Services (DHHS or Department). [redacted] registered nurse and Medicaid Utilization Analyst, testified as a witness 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] year-old Medicaid beneficiary who has been diagnosed with spinal muscular atrophy. (Exhibit A, pages 11-12).

2. Appellant had been receiving [redacted] hours per day of PDN through the Department. (Testimony of Appellant's representative; Testimony of Department's analyst).

3. On [redacted], the Department received a prior authorization request to renew the approval of PDN. (Exhibit A, pages 28-68).

4. In response, the Department sent Appellant's nursing provider, [redacted], a request for additional information. (Exhibit A, pages 7-8).

5. The nursing provider subsequently sent additional information to the Department. (Exhibit A, pages 11-27).

6. Overall, the submitted information provided that Appellant had not had any visits to the emergency room or vent clinic during the time period reviewed; she had only had [redacted] hospitalization in the last [redacted] months; and that she only received skilled tracheostomy suctioning [redacted] to [redacted] times in any [redacted] to [redacted] hour shift, with the most frequent occasion being suctioned [redacted] times in [redacted] hours and the least frequent occasion being suctioned [redacted] times in [redacted] hours. (Exhibit A, pages 40-67; Testimony of Department's analyst).

7. On [redacted], the Department sent Appellant's mother a Notification of Transitional Reduction of Private Duty Nursing Services. (Exhibit A, pages 9-10).

8. In that notification, the Department stated that Appellant's PDN would be reduced to [redacted] hours per day on [redacted]. (Exhibit A, page 9).

9. Regarding the reason for the reduction, the notification also stated:

> This decision is based on a recent review of medical documentation from Hospital Discharge Summary dated [redacted] and nursing notes from [redacted] covering [redacted] to [redacted]. This review indicates that a change in the authorized services is warranted because:
> The Beneficiary no longer meets medical criteria for [redacted] hours of Private Duty Nursing as evidence by:
> - No ER or Vent Clinic visits
> - Documentation submitted reflects that the beneficiary has had [redacted] hospitalization within the last [redacted] months.
> - Nurse's notes indicate that the beneficiary has only required suctioning [redacted] times within a [redacted] hour period (shift).
>
> *Exhibit A, page 9*

10. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding that reduction. (Exhibit A, pages 4-6).

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 case involves a reduction in private duty nursing (PDN) services and, with respect to such services, the Michigan Medicaid Provider Manual (MPM) states in part:

> **SECTION 1 – GENERAL INFORMATION**
>
> 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)
>
> 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.

Beneficiaries who are receiving PDN services through one Medicaid program cannot seek supplemental PDN hours from another Medicaid Program (i.e., Children's Waiver, Habilitation Supports Waiver, MI Choice Waiver).

1.1 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.

* * *

1.7 BENEFIT LIMITATION

The purpose of the PDN benefit is to assist the beneficiary with medical care, enabling the beneficiary to remain in their home. The benefit is not intended to supplant the caregiving responsibility of parents, guardians, or other responsible parties (e.g., foster parents). There must be a primary caregiver (i.e., parent, guardian, significant other adult) who resides with a beneficiary under the age of 18, and the caregiver must provide a monthly average of a minimum of eight hours of care during a typical 24-hour period. The calculation of the number of hours authorized per month includes eight hours or more of care that will be provided by the caregiver during a 24-hour period, which are then averaged across the hours authorized for the month. The caregiver has the flexibility to use the monthly-authorized hours as needed during the month.

> The time a beneficiary is under the supervision of another entity or individual (e.g., in school, in day/child care, in work program) cannot be used to meet the eight hours of obligated care as discussed above, nor can the eight hours of care requirement for beneficiaries under age 18 be met by other public funded programs (e.g., MDCH Home Help Program) or other resources for hourly care (e.g., private health insurance, trusts, bequests, private pay).
>
> *MPM, July 1, 2015 version*
> *Private Duty Nursing Chapter, pages 1, 7*

Moreover, with respect to care requirements for PDN, the MPM also provides in part:

> **SECTION 2 – CARE REQUIREMENTS**
>
> **2.1 PLAN OF CARE**
>
> 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. They must give informed consent for the planned services by signing and dating the POC annually and when updating the POC as needed based on the beneficiary's medical needs.
>
> - 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.

* * *

2.4 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.	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.	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 (prior authorized and billed in [redacted]-minute increments) that can be authorized under the Medicaid PDN benefit and defines the "benefit limitation" for individual beneficiaries. The Decision Guide 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., time) 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.

* * *

2.6 CHANGE IN BENEFICIARY'S CONDITION/PDN AS A TRANSITIONAL BENEFIT

Medicaid policy requires that the integrated plan of care (POC) be updated as necessary based on the beneficiary's medical needs. Additionally, when a beneficiary's condition changes, warranting a decrease in the number of approved hours or a discontinuation of services, the provider must report the change to the appropriate authorizing agent (i.e., the Program Review Division, Children's Waiver, or Habilitation Supports Waiver) in writing. Changes such as weaning from a ventilator or tracheostomy decannulation can occur after months or years of services, or a beneficiary's condition may stabilize to the point of requiring fewer PDN hours or the discontinuation of hours altogether. It is important that the provider report all changes resulting in a decrease in the number of hours to the authorizing agent as soon as they occur, as well as properly updating the POC. MDCH will seek recovery of monies inappropriately paid to the provider if, during case review, the authorizing agent determines that a beneficiary required fewer PDN hours than was provided and MDCH was not notified of the change in condition.

In some cases, the authorized PDN services may be considered a transitional benefit. In cases such as this, one of the primary reasons for providing services should be to assist the family or caregiver(s) to become independent in

> the care of the beneficiary. The provider, in collaboration with the family or caregiver(s), may decide that the authorized number of hours should be decreased gradually to accommodate increased independence on the part of the family, caregiver(s), and/or beneficiary. A detailed exit plan with instructions relating to the decrease in hours and possible discontinuation of care should be documented in the POC. The provider must notify the authorizing agent that hours are being decreased and/or when the care will be discontinued.
>
> *MPM, July 1, 2015 version*
> *Private Duty Nursing Chapter, pages 9, 11-12, 15*

The above policy therefore provides that, when a beneficiary's condition changes, those changes may warrant a decrease in the number of approved PDN hours.

Here, pursuant to the above policy, the Department decided that Appellant's PDN should be reduced to [redacted] hours per day. In support of that determination, its analyst testified that she reviewed the documentation submitted by Appellant's nursing provider and that the documentation reflected that Appellant had stabilized and required less PDN than before. In particular, the Department's witness noted that Appellant had not had any visits to the emergency room or the vent clinic; Appellant had only been hospitalized once in the past [redacted] months; and that the nurses' notes provided that Appellant only required suctioning [redacted] to [redacted] times within any single [redacted] to [redacted] hour shift. She further testified that the nurses' notes were from [redacted] separate days, including days when Appellant was stable and days when she had acute episodes. The Department's analyst also testified that nasal or oral suctioning, which Appellant does require more frequently, does not constitute skilled nursing care and that, based on the skilled nursing care Appellant does require, she falls within the medium intensity of care category on the Decision Guide used by the Department to calculate PDN hours. The analyst further testified that Appellant is receiving the maximum allowed under that guide given her intensity of care category and other circumstances.

In response, Appellant's mother testified that Appellant has a terminal, degenerative condition and requires around-the-clock care, including suctioning at least [redacted] an hour. She also testified that she does not know why the nursing notes would fail to reflect Appellant's needs or the care provided, but that the nursing provider has recently switched to a new system of entering notes. Appellant's mother further testified that Appellant did go to the emergency room in [redacted] and that she has a homebound teacher because she has been deemed too unstable to attend school. Appellant's mother also testified that there is no way for her to obtain employment or attend school herself if the hours are reduced and that she will be starting online classes soon.

Appellant bears the burden of proving by a preponderance of the evidence that the Department erred in deciding to reduce Appellant's PDN services. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Department's decision in light of the information that was available at the time the decision was made.

Given the record and available information in this case, the undersigned Administrative Law Judge finds that Appellant has failed to meet her burden of proof and that the Department's decision must therefore be affirmed. For whatever reason, the information submitted along with the prior authorization request in this case simply does not support Appellant's mother's testimony regarding Appellant's needs and the care provided, and the Department must rely on the information that is actually provided. Moreover, as that submitted information does not demonstrate that Appellant requires nursing assessments, judgments or interventions by a licensed nurse at least one time each hour throughout a [redacted] period she falls, at most, into the medium intensity of care category on the Decision Guide used by the Department and, given that category and her other circumstances, she is receiving the maximum amount of PDN allowed under that guide..

To the extent Appellant's needs change or her representative has new or updated information to provide, Appellant can always request an increase in PDN hours. With respect to the decision at issue in this case however, the Department's decision to reduce her PDN to [redacted] hours per day must be affirmed given the information available at the time.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED THAT:

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

Steven Kibit

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

[redacted]
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SJK/db

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.