RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

MIKE ZIMMER
DIRECTOR

[redacted]

Date Mailed: March 22, 2016
MAHS Docket No.: 15-020642
[redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, an in-person hearing was held on [redacted] Petitioner's mother and co-guardian, appeared and testified on Petitioner's behalf. [redacted] Petitioner's father and co-guardian, and [redacted], a Nurse Supervisor at [redacted] also testified as witnesses for Petitioner. Petitioner himself was present, but did not otherwise participate. [redacted], Medicaid Fair Hearings Officer, appeared on behalf of Respondent [redacted]. [redacted], Supports Coordinator; [redacted], Supports Coordinator; and [redacted], Director of Quality and Compliance; from [redacted] testified as witnesses for Respondent. [redacted], a Medicaid Fair Hearings Officer trainee with Respondent, was also present, but did not otherwise participate.

ISSUE

Did Respondent properly terminate Petitioner'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. Petitioner's was born on [redacted] and diagnosed with tracheoesophageal fistula (TEF) at birth. (Exhibit A, pages 7, 26).

2. He then underwent an unsuccessful surgery; was both tracheostomy and ventilator dependent for [redacted] months; and did not leave the hospital until he was over a year old. (Exhibit A, page 26).

3. At that time or later, Petitioner was also diagnosed with attention to tracheostomy; attention to gastrostomy; asthma; moderate mental impairment or developmental delay NOS; and left eye blindness. (Exhibit A, pages 7, 9, 18).

4. After leaving the hospital, Petitioner was approved for PDN services through the Children's Home and Community Based Services Waiver Program (CWP). (Testimony of Petitioner's mother; Testimony of [redacted].

5. Petitioner has not has had any emergency room visits or hospitalizations since age[redacted], but he does have a history of upper respiratory infections that require antibiotics. (Exhibit A, page 26)

6. During his childhood, Petitioner also had seizures until age f[redacted] or f[redacted] and a failed removal of his tracheostomy at age [redacted] left him with paralyzed vocal cords and non-verbal. (Exhibit A, page 26).

7. Additionally, his G-tube/Mic Key button placement site had to be revised several times, which left him with scar tissue. (Exhibit A, page 26; Testimony of Petitioner's Father).

8. In a [redacted] review by [redacted], it was noted that Petitioner's PDN Intensity of Care category was being changed to Medium as Petitioner was being suctioned approximately every[redacted] to [redacted] hours, but had not required oxygen during the last quarter reviewed and his bedside vent is only used when he has an upper respiratory infection. (Exhibit A, page 13).

9. During a [redacted] Comprehensive Assessment, it was noted that Petitioner did not require oxygen or ventilation, but still had a tracheostomy, G-tube and Mic Key button. (Exhibit A, pages 15-16).

10. His goals at that time included safety, no emergent trach or g-tube changes, no upper respiratory infections, no urinary tract infections, socializing and nutrition; and the nurse reviewer checked that Petitioner was making adequate progress toward those goals. (Exhibit A, page 18).

11. In a Home Health Certification and Plan of Care for [redacted] through [redacted], it was noted that a nursing provider, [redacted] would provide nursing care related to Petitioner's tracheostomy, with Petitioner's parents performing changes while the nurse would only perform emergent changes and suctioning as needed; Petitioner's mist collar; Petitioner's gastrostomy care, including changing the G-tube and Mic Key button; and musculoskeletal care, with an assessment of Petitioner's skin every shift. (Exhibit A, pages 10-11).

12. The Plan of Care at that time also provided that care "remains medically necessary due to airway monitoring/maintenance, tube feed administration, medication administration/reconciliation, assistance with ADLs, musculoskeletal development/endurance, PCG/patient education, staff supervision, care coordination, development/revision of client-centered treatment plan and PCG relief." (Exhibit A, page 11).

13. When Petitioner turned [redacted]-years-old, on [redacted], he transitioned from the CWP onto the Habilitation Supports Waiver (HSW), which is administered by Respondent pursuant to its contract with the Michigan Department of Health and Human Services. (Testimony of [redacted]

14. Once on the HSW, Petitioner continued to receive [redacted] to [redacted] hours per day of PDN, depending on whether Petitioner is in school regularly or not, in addition to respite nursing care. (Testimony of [redacted]

15. Petitioner also received nursing services through his school while he is there. (Exhibit A, page 30).

16. On [redacted], Registered Nurse (RN) [redacted] completed a review and PDN Eligibility Determination Worksheet with respect to Petitioner's PDN services. (Exhibit A, pages 26-29).

17. In that worksheet, she wrote that she reviewed the skilled nursing notes, suctioning notes, parent reports, and nursing objective assessments. (Exhibit A, page 27).

18. She also noted that Petitioner had not had any significant infections leading to emergency room visits or hospitalizations in the past year, but that the lack of medical issues may have been partly due to the continuous monitoring and preventative measures provided by the nursing and parental care. (Exhibit A, page 27).

19. With respect to the tracheostomy, [redacted]r specifically found that it is used daily, with the tube changed and cleaned daily and the tracheostomy itself changed monthly. (Exhibit A, page 28)

20. With respect to the feeding tube/Mic Key button, [redacted] found that it is used every [redacted] hours during the day and continuously throughout the night, with routine changing, cleaning and monitoring of the site given Petitioner's history of redness. (Exhibit A, page 29).

21. With respect to suctioning, [redacted] specifically found that any suctioning is deep suctioning and requires skilled nursing, but that it is only completed a few days during a few months in the year. (Exhibit A, page 28).

22. Taylor further specifically found that a ventilator and oxygen were not used, and that a Pulse Oximeter was used rarely. (Exhibit A, page 28).

23. Overall, [redacted]r checked a Low Intensity of Care category for Petitioner of choices of High, Medium and Low. (Exhibit A, page 28).

24. She also recommend that Petitioner:

> Does not meet requirement for continuous need for licensed nursing care on a daily basis. [Petitioner's] parents care for him on alternative [sic] weeks (divorced, different households) and utilized two separate nursing agencies to render his care (Maxim and Healthcall). Both agencies provided some documentation that did not support regular skilled nursing intervention (e.g. suctioning, daily injections, and ventilator with Bipap/C-pap). Some intermittent suction record sheets were provided from Health Call for months: [redacted] and [redacted] [Petitioner could benefit from a trained & certified medical worker (e.g. Certified Nursing Assistant, Medical Assistant, or home health aide), specifically at night while caregivers are sleeping and unable to monitor him or during activities in the community (school, camp, etc).
>
> *Exhibit A, page 26*

25. [redacted] subsequently sent Petitioner's parents written notice of a decision to terminate Petitioner's PDN services. (Testimony of Petitioner's Mother; Testimony of [redacted]

26. Petitioner's supports coordinator also telephoned the parents separately to discuss the Adequate Notice of Action for PDN that had been sent out. (Exhibit A, pages 46-47).

27. During a person-centered planning meeting in [redacted] regarding Petitioner's services, they also discussed Petitioner's services and it was noted that Petitioner's family will approve nursing staff and

provide information to assess Petitioner's level of care. (Exhibit A, page 37).

28. On [redacted], Petitioner's mother telephoned Petitioner's supports coordinator and advised her of Petitioner's decline in health since the PDN servicers were discontinued and how his Mic Key button had been leaking and presenting problems. (Exhibit A, page 49).

29. On [redacted], Petitioner's supports coordinator telephoned Petitioner's mother about reinstating Petitioner's PDN services and the upcoming revaluation. (Exhibit A, page 50).

30. On [redacted], RN [redacted]r conducted another review in which the same conclusion and recommendation were reached. (Exhibit A, pages 30-33).

31. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding the termination of PDN services. (Exhibit A, page 5).

32. Petitioner's PDN services were then reinstated pending the hearing. (Testimony of Petitioner's Mother; Testimony of [redacted]

33. On [redacted], MAHS sent the parties written notice of a telephone hearing scheduled for [redacted]. (Exhibit A, page 1).

34. The parties appeared for the hearing on that date, but Petitioner's representative subsequently requested that the matter be adjourned so that she could have an opportunity to review Respondent's proposed exhibits and so that the hearing could be held by the presiding judge in-person. (Exhibit A, pages 2-3).

35. Respondent did not object to any adjournment and the undersigned Administrative Law Judge then granted Petitioner's request on the record. (Exhibit A, pages 2-3).

36. On [redacted], the undersigned Administrative Law Judge issued an Order Granting Adjournment and Notice of a Rescheduled Hearing scheduled for [redacted]. (Exhibit A, pages 2-3).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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…
>
> *42 USC 1396n(b)*

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 (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

This case involves a termination of private duty nursing (PDN) services for a Medicaid beneficiary under age 21 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.
>
> For beneficiaries 21 and older, PDN is a waiver service that may be covered for qualifying individuals enrolled in the Habilitation Supports Waiver or MI Choice Waiver. When PDN is provided as a waiver service, the waiver agent must be billed for the services.

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.

* * *

1.3 PROVISION OF PRIVATE DUTY NURSING

PDN must be ordered by a physician and provided by a Medicaid enrolled private duty nursing agency, a Medicaid enrolled registered nurse (RN), or a Medicaid enrolled licensed practical nurse (LPN) who is working under the supervision of an RN (per Michigan Public Health Code). It is the responsibility of the LPN to secure the RN supervision.

* * *

1.4 PRIOR AUTHORIZATION

PDN services must be authorized by the Program Review Division, the Children's Waiver, or the Habilitation Supports Waiver before services are provided. (Refer to the Directory Appendix for contact information.) PDN services are authorized and billed in 15-minute incremental units (1 unit = 15 minutes). Prior authorization of a particular PDN provider to render services considers the following factors:

- Available third party resources.
- Beneficiary/family choice.
- Beneficiary's medical needs and age.
- The knowledge and appropriate nursing skills needed for the specific case.
- The understanding of the concept and delivery of home care and linkages to relevant services and health care organizations in the area served.

The Private Duty Nursing Prior Authorization – Request for Services form (MSA-0732) must be submitted when requesting PDN for persons with Medicaid coverage before services can begin and at regular intervals thereafter if continued services are determined to be necessary. A copy of the form is provided in the Forms Appendix and is also available on the MDCH website. (Refer to the Directory Appendix for website information.) This form is **not** to be used for beneficiaries enrolled in, or receiving case management services from, the Children's Waiver, Habilitation Supports Waiver, or MI Choice Waiver. Private Duty Nursing is not a benefit under CSHCS. Individuals with CSHCS coverage may be eligible for PDN under Medicaid.

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 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 units or a discontinuation of services, the provider must report the change to the Program Review Division. (Refer to the Directory Appendix for contact information.) It is important that the provider report all changes as soon as they occur, as well as properly updating the plan of care. The request to increase or decrease units must be accompanied by an updated and signed POC; and documentation from the attending physician addressing the medical need if the request is for an increase in PDN units.

Often the request to begin services will be submitted by a PDN agency or individual PDN; however, a person other than the PDN provider (such as the hospital discharge planner, CSHCS case manager, physician, or physician's staff person) may submit the MSA-0732. When this is the case, the person submitting the request must do so in consultation with the PDN agency or individual PDN who will be assuming responsibility for the care of the beneficiary.

If services are requested for more than one beneficiary in the home, a separate MSA-0732 must be completed for each beneficiary.

The PA number is for private duty nursing only. Any CMHSP prior authorized respite services must be billed to the authorizing CMHSP.

1.4.A. DOCUMENTATION REQUIREMENTS

The following documentation is required for all PA requests for PDN services and must accompany the MSA-0732:

- Most recent signed and dated nursing assessment, including a summary of the beneficiary's current status compared to their status during the previous authorization period, completed by a registered nurse;

- Nursing notes for two (2) four-day periods, including one four-day period that reflects the most current medically stable period and another four-day period that reflects the most recent acute episode of illness related to the PDN qualifying diagnosis/condition;

- Most recent updated plan of care (POC) signed and dated by the ordering/managing physician, RN, and the beneficiary's parent/guardian. The POC must support the skilled nursing services requested;

The POC must include:

- Name of beneficiary and Medicaid ID number

- Diagnosis(es)/presenting symptom(s)/condition(s)

- Name, address, and telephone number of the ordering/managing physician

- Frequency and duration of skilled nursing visits, and the frequency and types of skilled interventions, assessments, and judgments that pertain to and support the PDN services to be provided and billed

- Identification of technology-based medical equipment, assistive devices (and/or appliances), durable medical equipment, and supplies

- Other services being provided in the home by community-based entities that may affect the total care needs

- List of medications and pharmaceuticals (prescribed and over-the-counter)

- Statement of family strengths, capabilities, and support systems available for assisting in the provision of the PDN benefit (for renewals, submit changes only)

- All hospital discharge summaries for admissions related to the PDN qualifying diagnosis/condition within the last authorization period; and

- Other documentation as requested by MDCH.

1.4.B. BENEFICIARY ELIGIBILITY

Approval of the MSA-0732 confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDCH will not reimburse the provider for services provided and billed. To assure payment, the provider must verify beneficiary eligibility monthly at a minimum.

* * *

1.6 GENERAL ELIGIBILITY REQUIREMENTS

The beneficiary is eligible for PDN coverage when all of the following requirements are met:

- The beneficiary is eligible for Medicaid in the home/community setting (i.e., in the noninstitutional setting).

- The beneficiary is under the age of 21 and meets the medical criteria for PDN.

- PDN is appropriate, considering the beneficiary's health and medical care needs.

- PDN can be provided safely in the home setting.

- The beneficiary, his family (or guardian), the beneficiary's physician, the Medicaid case manager, and RN (i.e., from the PDN agency or the Medicaid enrolled RN, or the supervising RN for the Medicaid enrolled LPN) have collaborated and developed an integrated plan of care (POC) that identifies and addresses the beneficiary's need for PDN. The PDN must be under the direction of the beneficiary's physician; the physician must prescribe/order the services. The POC must be signed and dated by the beneficiary's physician, RN (as described above), and by the beneficiary or beneficiary's parent/guardian. The POC must be updated at least annually or more frequently as needed based on the beneficiary's medical needs.

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).

* * *

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 8 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.

MPM, July 1, 2015 version
Private Duty Nursing Chapter, pages 1-7, 9-11

Here, Respondent asserts that it terminated Petitioner's PDN services pursuant to the above policy. Specifically, its witnesses summarized the annual review completed by an RN in [redacted] and her conclusion that Petitioner did not meet the specific criteria in policy for PDN given his lack of need for continuous skilled nursing care on a daily basis. The witnesses also noted the reviewer's determination that Petitioner's needs could be met through the use of a trained and certified medical worker, such as a Certified Nursing Assistant, Medical Assistant, or home health aide.

In response, Petitioner's mother testified that Petitioner has had nursing services for [redacted] years that he has only remained healthy because of the proactive and preventative care provided by his parents and the nurses. She also testified that Petitioner needs a nurse or someone else that can care for his needs with him at all times and that, while his parents have become well-versed in how to care for him, they cannot provide the care Petitioner needs without the nurses. She further noted that, although not on a 1:1 basis, Petitioner has a nurse with him on the bus and at school, with the school having determined that a nurse is required. According to Petitioner's mother, Petitioner's two primary concerns are respiratory infections, which Petitioner has a history of, and G-tube functioning, which is always a challenge as the tube leaks and the button has popped out. She also testified that the tracheostomy suctioning, which is done at least [redacted] times a day, is a prophylactic measure used to prevent the secretions that can lead to respiratory infections and that Petitioner will be dealing with both his tracheostomy and his G-tube for the rest of his life.

Petitioner's father similarly testified regarding Petitioner's need the PDN and how a normal respite worker cannot provide the care Petitioner needs. He also testified that, during the time Petitioner did not have nursing, his G-tube/button site broke down

severely and that he cannot keep losing sites as there are only so many times it can be changed.

The Nurse Supervisor from one of Petitioner's nursing providers further testified regarding his concerns whether any non-nurse would be allowed to provide all the care Petitioner needs and whether they would have the necessary skill-set if there is an emergency. He also testified that Petitioner has been very stable, but that is only because of the care he has been receiving. With respect to skilled nursing provider, the Nurse Supervisor identified assessments of Petitioner's tracheostomy and deep oral suctioning, although he also testified that suctioning is not needed very often.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in terminating his PDN services.

Given the record in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet that burden of proof and that Respondent's decision must be affirmed. While the nurse reviewer did not testify and the specific documents she relied upon are not in the record, her report and recommendation clearly outline what she found and the basis for her conclusion that Petitioner did not require continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services, as required under the above policy discussing Medical Criteria III and which Petitioner would have to meet even if he met Medical Criteria I or Medical Criteria II. Moreover, the nurse supervisor who testified for Petitioner confirmed the nurse reviewer's findings, as the only skilled nursing care he identified was routine tracheostomy assessments and rare suctioning. Accordingly, while Petitioner's mother testified that Petitioner requires frequent, deep suctioning as a prophylactic measure, her testimony is unpersuasive as it is directly contradicted by the nurse supervisor's testimony and the nurse reviewer's report.

Petitioner's other arguments are likewise unpersuasive. For example, while Petitioner may be receiving nursing services at school and on the bus, the basis for that services and the criteria used in approving them is absent from the record and, regardless, Petitioner would still have to meet the specific criteria identified above. Moreover, while both of Petitioner's parents testified regarding the need for skilled nursing in caring for Petitioner's G-tube and Mic Key button site, the above policy expressly states that equipment needs alone do not create the need for skilled nursing services and there is no testimony that the care of Petitioner's equipment requires skilled nursing or how often such assessments or interventions are required.

It is undisputed that Petitioner has been stable while receiving PDN services, but Petitioner has failed to meet his burden of showing that PDN, as opposed to other types of care, is medically necessary and that he meets the specific criteria for such services identified in policy. Accordingly, Respondent's decision must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly terminated Petitioner's private duty nursing services.

IT IS THEREFORE ORDERED that

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

Steven Kibit

SK/db

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

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 Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS 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. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

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

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

DHHS -Dept Contact

[redacted]

DHHS-Location Contact

[redacted]

Petitioner

[redacted]