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:

Docket No. 15-011872 PAC

[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/Petitioner.

After due notice, a hearing was held on [redacted] Appellant, a minor, was represented by [redacted] who also testified on behalf of Appellant.

[redacted], Appeals Review Officer, represented and testified on behalf of the Department of Health and Human Services (Department). No other witness(es) appeared or testified on behalf of the Department.

ISSUE

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

PROCEDURAL HISTORY

1. On [redacted] the Department issued notice approving Appellant for [redacted] hours of private duty nursing (PDN) per day.

2. On [redacted] the Department issued a Notification of Reduction/Termination of PDN hours stating: "Effective [redacted] authorization will continue at [redacted] hours/day. Effective [redacted] authorization will be at [redacted] hours/day." The reduction states that the decision was based on "The original authorization dated [redacted] from the inpatient setting which included the beneficiary's requirement of a mechanical ventilator n the home setting. Mechanical ventilation has not been required in the home setting, after all." (Exhibit A.5).

3. On [redacted] the Department issued a Notice of Authorization that Appellant is approved [redacted] hours per day of PDN from [redacted] to [redacted]. (Exhibit A. Addendum).

4. On [redacted] the Department issued a Notice of Authorization that Appellant is approved [redacted] hours of PDN from [redacted] to [redacted] (Exhibit A. Addendum).

5. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on Appellant's behalf in this matter and disputing the reduction in PDN services. (Exhibit A.4). The action took place.

6. On [redacted] MAHS scheduled an administrative hearing. At the time and place for the hearing, the Appellant's representative objected to going forward on the grounds that Appellant had not received a copy of the Department's proposed [redacted] page Exhibit, along with the Addendum faxed to MAHS on [redacted] An adjournment was granted.

7. On 1[redacted] at the rescheduled hearing, the Department requested that there be another adjournment on the grounds that the Department's witness was not available for the hearing. The Department's request for a second adjournment was denied on the grounds that: because the action has already taken place, further delay can potentially prejudice Appellant; on the grounds that there was a previous adjournment due to the Department due to the Department having failed to timely issue an evidentiary packet to Appellant; and on the grounds that a second adjournment would violate the [redacted] day federal requirement time frame.

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 male Medicaid beneficiary who has a history of ependymoma, tracheostomy dependent, port catheter, hydrocephalus-shunted, tracheitis, GERD, vagus nerve injury, dysphagia. (Exhibit A.67).

2. In [redacted], Appellant was hospitalized with chronic conditions listed in Finding of Fact #1, as well as difficulty swallowing, disturbance of salivary secretion, eustachian tube dysfunction, vocal cord paresis, fever, staph aureus infection, pneumonia, vomiting, increased trach secretions, headaches, abdominal pain around his G tube site, diarrhea,. (Exhibit A.67).

3. Since [redacted], Appellant's condition has worsened. Appellant needs more trach care, cancer, and radiation. (Testimony).

4. In [redacted] the Department approved [redacted] hours of PDN per day.

5. Appellant has never had a mechanical ventilator at home. (Testimony; PDN notes over [redacted] month period).

6. In [redacted] the Department reduced the hours to [redacted] stating in part: "The original authorization dated [redacted] from the inpatient setting which included the beneficiary's requirement of a mechanical ventilator in the home setting. Mechanical ventilation has not been required in the home setting, after all." (Exhibit A.5).

7. Appellant uses the hours during the night for suctioning, assistance to the restroom, and for his primary caregiver to sleep, with the [redacted] hour overlap to assist with Appellant's medical needs. (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.

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)
- Home and Community-Based Services Waiver for the Elderly and Disabled (the MI Choice Waiver)

For a Medicaid beneficiary who is not receiving services from one of the above programs, the Program Review Division reviews the request for authorization and authorizes the services if the medical criteria and general eligibility requirements are met.

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).

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.

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 15-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, 2014 version*
> *Private Duty Nursing Chapter, pages 9, 11-12, 15*
> *(Emphasis added)*

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. Moreover, the weaning off of a ventilator is specifically identified as a change that may justify a reduction in PDN hours.

Here, pursuant to the above policy, the Department decided that Appellant's PDN should be reduced to 8 hours per day based on its review of the submitted documentation. However, the witness who made this decision was not available at the administrative hearing for testimony and/or cross-examination. The Department ARO

who did appear as a witness stated that she could not testify as to the reduction and that "I am not comfortable" testifying as to the evidence and documents in the evidentiary package as stated that "I do not have the background." The Department summarized the contents of the reduction notice, which referenced treatment plans from [redacted] through [redacted]'. The only specific, substantive reason given on the reduction notice states that the reduction was due to "…mechanical ventilation has not been required…" (Exhibit A.5). No other specific reason is stated. In addition, the ARO testified that the PDN program is a transitional program.

Appellant's representative argues that nothing has changed, that she has never been given any medical evidence that the Department purports to have relied on-evidence that Appellant was using a mechanical ventilator. Moreover, Appellant's representative states that the PDN notes since [redacted] completed on a regular basis and delivered to the Department for ongoing review have never made reference to a mechanical ventilator. In addition, the representative argues that in fact, Appellant's condition has worsened, that there are now more complications, including cancer, radiation treatments, and stunt issues.

Appellant's statements are credible in light of the fact that based on the [redacted] month approval period in the [redacted] notice, the Department apparently approves and/or reassess every [redacted] months or so. This means that the Department has continually approved Appellant on at least [redacted] occasions for [redacted] hours despite having knowledge based on the treatment notes that Appellant has not and never has used mechanical ventilation.

Basic to due process and general evidentiary considerations, an individual has a right to examine the Department's evidence that was used, to adequately prepare for an hearing, and to examine and cross-examine that evidence including the witness(es).

These rights are cemented in a number of laws, statutes and policies in [redacted]. Some of these are as follows: "Claimants cannot know whether a challenge to an agency's action is warranted, much less formulate an effective challenge, if they are not provided with sufficient information to understand the basis for the agency's action." *Kapps*, 404 F.3d at 124.

These legal tenets are part of basic evidentiary requirements in American jurisprudence and documented in numerous state law, policy and rules. In the Department of Licensing and Regulatory Affairs, MAHS, Administrative Hearing Rules, Rule 106 requires the ALJ to examine witnesses necessary to complete a record. Rule 106(1)(l), and under R 792.10128, Rule 128(d) opposing parties shall be entitled to cross-examine witnesses. The inability to examine all witnesses also violates the due process rights under the Rights of parties section R 792.11008 wherein it states that a claimant has the right to "question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses." Rule 792.11008(i).

In addition, Department of Licensing and Regulatory Affairs, MAHS, Administrative Rules, and as applicable the provisions of Chapter 4 of the Michigan Administrative Procedures Action of 1969, 1969 PA 306, MCL 24.271 to 24.287 apply. MAPA specifically indicates in 24.272 that "A party may cross-examine a witness, including the author of a document prepared by, on behalf of, or for the use of the agency and offered into evidence. The party may submit rebuttal evidence." MAPA, 24.272(4).

BAM 600 also states:

> Both the local office and the client or AHR must have adequate opportunity to present the case, bring witnesses, establish all pertinent facts, argue the case, refute any evidence, cross-examine adverse witnesses, and cross-examine the author of a document offered in evidence. P 36.

The federal requirements found at 42.CFR cited above, as well as those cited above in the state laws, policies and rules, are not extra verbiage. They are specifically intended to protect and ensure that the individual has a right to understand the action the state intends to take, the reasons, and the specific regulations that support the action, and to ensure that the hearing process is fair and allows both sides to prepare and understand the evidence brought forth. 42 CFR 431.210, 211, 213; MAC R 792.11003; BAM 600; ASM 165; and DCH Administrative Hearing Pamphlet.

Here, Appellant requested the medical documentation regarding the ventilator. The evidentiary packet was not delivered to Appellant in time for the first administrative hearing. Nor was it delivered to Appellant for the second administrative hearing, and only faxed to the ALJ on the eve of the second hearing. When the hearing went forward despite Appellant not having received the purported documentation regarding the mechanical ventilator, it was then, on the record, that Appellant was informed verbally that it was based on the [redacted] addendum.

More importantly, the Department employee who made the decision here was not available at the administrative hearing for testimony and/or cross-examination, significantly impairing Appellant's ability to question the witness. Appellant was credible. Moreover, the decision did not comport with policy regarding a weaning of a ventilator. The Department witness who was present at the administrative hearing testified that she was not comfortable referencing the medical documentation.

In addition, that witness argued that the PDN program is a transition program. However, the clear language of the MPM cited above states: "In some cases, the authorized PDN services may be considered a transitional benefit." MPM see above. 'In some cases' is a phrase that does not connote that the program is in fact a transitional program; rather, it could be in 'some cases.' In addition, Appellant's representative argued that Appellant's condition has actually worsened. Appellant was a credible witness.

Here, the Department did not meet its burden of going forward. Appellant and her representative bear the burden of proving by a preponderance of the evidence that the Department erred in deciding to reduce Appellant's PDN services. PDN is not a program that is by policy transitional. And the facts here, cannot be reasonably construed as a situation where the Appellant's condition is such that he has improved.

Given the record in this case, Appellant and her representative have met that burden of proof and the decision to reduce Appellant's PDN services must be reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department improperly decided to reduce Appellant's private duty nursing services.

IT IS THEREFORE ORDERED THAT:

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

Janice G. Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

JGS/db

cc: [redacted]

***** NOTICE *****

The Michigan Administrative Hearing System for the Department of Community Health 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 Community Health 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.