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: [redacted]
MAHS Docket No.: 16-000315
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Colleen Lack

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* upon the Petitioner's request for a hearing.

After due notice, a hearing was held on [redacted][1]. [redacted], father, appeared on behalf of the Petitioner. [redacted], Appeals Review Officer, represented the Department of Health and Human Services (Department). [redacted], RN, Medicaid Utilization Analyst, appeared as a witness for the Department.

The hearing was originally scheduled for [redacted]. The Department's request for an adjournment was granted. The hearing was re-scheduled for [redacted].

During the hearing proceedings, the following exhibits were admitted:

A. Department's Hearing Summary Packet for Petitioner's case pp. 1-151
A-1. Department's first Addendum Packet for Petitioner's case pp. 1-10
A-2. Department's second Addendum Packet for Petitioner's case pp. 1-13

B. Department's Hearing Summary Packet for Petitioner's sister's case pp. 1-166
B-1. Department's first Addendum Packet for Petitioner's sister's case pp. 1-10
B-2. Department's second Addendum Packet for Petitioner's sister's case pp. 1-13

[1] The Petitioner's case was held in conjunction with 16-000314. The Petitioners in both cases are sisters and the appeals involved the same types of case actions.

ISSUE

Did the Department properly reduce Petitioner's Private Duty Nursing (PDN) hours?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Petitioner is a [redacted] year old Medicaid beneficiary, date of birth [redacted], with diagnosis including Pompe disease, glycogenosis, ventilator and oxygen dependent, acute and chronic respiratory failure, congenital heart block, g-tube, and staring spell for which Petitioner will undergo assessment for seizure disorder. (Exhibit A, pp. 19-133; Exhibit A-1, pp. 1-5; Exhibit A-2, pp. 1-13)

2. On [redacted], the Petitioner was approved for Medicaid-covered PDN care, 16 hours per day for 90 days after discharge. (Exhibit A, pp. 14-15)

3. On [redacted], and [redacted], the Department received requests for renewal of PDN services sent by Petitioner's PDN providers. (Exhibit A, pp. 20 and 78; Exhibit A-1, p. 1)

4. On [redacted], the Department issued a Notice of Transitional Reduction of Private Duty Nursing Services to the Petitioner indicating that her PDN hours would be decreased transitionally from 16 hours per day from [redacted], thru [redacted]; to 14 hours per day from [redacted], thru [redacted]; and then 12 hours per day from [redacted], thru [redacted]. The Notice indicated the reduction was based on a review the listed medical documentation and Petitioner not meeting medical criteria for 16 hours of PDN as evidenced by no hospitalizations within the last six months and no emergency room visits within the last six months. (Exhibit A, pp. 10-11)

5. On [redacted], the Petitioner's hearing request was received by the Michigan Administrative Hearing System. (Exhibit A, pp. 5-9)

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.

The Medicaid Provider Manual addresses general information about PDN:

> 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).
>
> Medicaid Provider Manual,
> Private Duty Nursing,
> January 1, 2016, p. 1.

PDN services require prior authorization:

> **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 MDHHS 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 MDHHS 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 MDHHS 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.

Medicaid Provider Manual,
Private Duty Nursing,
January 1, 2016, pp. 3-4.

The Medicaid Provider Manual addresses benefit limitations and service logs:

1.7 BENEFIT LIMITATIONS

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 units 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 time authorized for the month. The caregiver has the flexibility to use the monthly-authorized units 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., MDHHS Home Help Program) or other resources for hourly care (e.g., private health insurance, trusts, bequests, private pay).

1.8 SERVICE LOG

If PDN is prior approved and care is initiated, a detailed log for each date of service must be maintained. The service log must be beneficiary specific, with the beneficiary's name and birth date in the header portion of the document. In cases where the nurse is caring for two or more beneficiaries in the same home, a separate service log for each beneficiary must be maintained. This log must be kept in the beneficiary's record.

Medicaid Provider Manual,
Private Duty Nursing,
January 1, 2016, p. 7.

The Medicaid Provider Manual also addresses when the nurse cares for more than one patient at a time:

1.13 CARING FOR MORE THAN ONE PATIENT AT A TIME

For ratios of more than two patients per nurse, the provider must contact the entity authorizing the beneficiary's 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 (MI Choice Waiver) or the Medicaid Program Review Division. These ratios are considered exceptional cases and require prior approval.

A PDN authorized to provide services to two children at the same location may find that, at times, only one child is present to receive services. This may occur when one child is in school, at a medical appointment, hospitalized, or on a family outing. The beneficiary record must document why only one child was present to receive services, as well as the

beginning and ending time of the services. (Refer to the appropriate Billing and Reimbursement chapter for billing instructions.)

Medicaid Provider Manual,
Private Duty Nursing,
January 1, 2016, p. 8.

The Medicaid Provider Manual addresses how the amount of PDN is determined:

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	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	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.

loss of function or death, or in acceleration of the chronic condition.	and judgments due to an inability to communicate 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., the 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.

When using the Decision Guide, the following definitions apply:

- "Caregiver": legally responsible person (e.g., birth parents, adoptive parents, spouses), paid foster parents, guardian or other adults who are

not legally responsible or paid to provide care but who choose to participate in providing care.

- "Full-time (F/T)": working at least 30 hours per week for wages/salary, or attending school at least 30 hours per week.
- "Part-time (P/T)": working at least 15 hours per week for wages/salary, or attending school at least 15 hours per week.
- "Significant" health issues: one or more primary caregiver(s) has a health or emotional condition that prevents the caregiver from providing care to the beneficiary (e.g., beneficiary weighs 70 pounds and has no mobility and the primary caregiver just had back surgery and is in a full-body cast).
- "Some" health issues: one or more primary caregiver(s) has a health or emotional condition, as documented by the caregiver's treating physician, that interferes with, but does not prevent, provision of care (e.g., caregiver has lupus, alcoholism, depression, back pain when lifting, lifting restrictions, etc.).
- "School" attendance: The average number of hours of school attendance per week is used to determine the maximum number of hours that can be authorized for the individual of school age. The average number of hours is determined by adding the number of hours in school plus transportation time. During planned breaks of at least 5 consecutive school days (e.g., spring break, summer vacation), additional hours can be authorized within the parameters of Factors I and II.

The Local School District (LSD) or Intermediate School District (ISD) is responsible for providing such "health and related services" as necessary for the student to participate in his education program. Unless medically contraindicated, individuals of school age should attend school. Factor III applies when determining the maximum number of hours to be authorized for an individual of school age. The Medicaid PDN benefit cannot be used to replace the LSD's or ISD's responsibility for services (either during transportation to/from school or during participation in the school program) or when the child would typically be in school but for the parent's choice to home-school the child.

2.5 EXCEPTION PROCESS

Because each beneficiary and his family are unique and because special circumstances arise, it is important to maintain an exception process to ensure the beneficiary's safety and quality of care. PDN services that exceed the beneficiary's benefit limitation, as established by the Decision Guide, must be prior authorized by the appropriate Medicaid case management program. Limited authority to exceed the published PDN benefit limitations may be granted on a time-limited basis as detailed below.

The beneficiary or his primary care giver must initiate the request for an exception. The applicable Medicaid case management program's representative is responsible for facilitating the request and documenting the necessity for an

exception. Factors underlying the need for additional PDN must be identified in the beneficiary's POC, which must include strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

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

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

A temporary alteration in the beneficiary's care needs following a hospitalization, resulting in one or both of the following:	**The temporary inability of the primary caregiver(s) to provide required care as the result of one of the following:** ("Inability" is defined as the caregiver is either unable to provide care or is prevented from providing care.)
• A temporary increase in the intensity of required assessments, judgments, and interventions. • A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs. The total number of additional PDN hours cannot exceed two hours per day, for a maximum of six months.	• An acute illness or injury of the primary caregiver(s). The total number of additional PDN hours cannot exceed two hours per day for the duration of the caregiver's inability, not to exceed six months. In the event there is only one caregiver living in the home and that caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. • The death of the primary caregiver(s) or an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours

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

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. MDHHS 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 MDHHS 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.
>
> Medicaid Provider Manual,
> Private Duty Nursing,
> January 1, 2016, pp. 11-15.

In this case, there is no dispute that the Petitioner meets the medical criteria for PDN. (See Medicaid Provider Manual, Private Duty Nursing, January 1, 2016, pp. 9-11) It was also uncontested the Petitioner's intensity of care is "High Category" pursuant to the above cited Medicaid Provider Manual Policy. Rather, the contested issue is the proposed decrease from 16 hours of PDN services per day to 12 hours of PDN services per day, with the transitional step at 14 hours of PDN services per day. The Department explained that the determination to decrease Petitioner's PDN hours was taken after a review of the submitted recent medical documentation and is in accordance with the Medicaid Provider Manual policy regarding the maximum hours of PDN that can be authorized. (Testimony of RN Medicaid Utilization Analyst)

The RN Medicaid Utilization Analyst noted that Petitioner initially approved for PDN on [redacted], for 16 hours per day for 90 days after discharge. (Exhibit A, pp. 14-15) It appears that it may have been an oversight by the Department to let the PDN hours continue at 16 hours per day for six years. (Testimony of RN Medicaid Utilization Analyst)

As cited above, the Decision Guide for Establishing Maximum Amount of PDN to be authorized on a Daily Basis, would only allow a maximum of 12 hours of PDN per day in Petitioner's current circumstances. Specifically, Petitioner is in the high intensity of care category and two caregivers are living in the home that neither work nor are in school at least part time. (Testimony of RN Medicaid Utilization Analyst) Additionally, there was no evidence of any significant health issues for the caregivers.

The documentation provided to the Department at the time of this case action included responses to the Department's request for additional information indicating there were no recent records from an ENT specialist in the past year and there are no bronchoscopy reports. (Exhibit A, pp. 16-17) [redacted] and [redacted] radiology reports of the left femur showed demineralization of the bones, contour irregularity that may represent fracture, diffuse osteopenia, and a healing femur fracture. (Exhibit A,

pp. 58-59) A [redacted], clinic record references a home/environment entry from [redacted], stating family and friends are available to help. While the Department also noted parts of a sentence in this clinic record indicating Petitioner had been doing fairly well and had no significant hospitalizations, the rest of the sentence indicates this related to her condition prior to [redacted]. (Exhibit A, p. 64 and 67) A [redacted], pulmonology consultation indicates a planned admission for IV hydration prior to an MRI, which did not end up being completed. It was noted that while Petitioner's father felt that Petitioner did not feel well, she had stable vital signs and her physical exam was within normal. The observation notes also state that Petitioner had not had any recent pneumonias or episodes of tracheitis and her last pulmonary clinic visit was on [redacted]. The impression and plan orders state that Petitioner was doing well from a respiratory standpoint. (Exhibit A, pp. 69-74) A [redacted], Home Health Certification and Plan of Treatment documented that Petitioner was undergoing IV infusion therapy with Myozyme once every two weeks. (Exhibit A, p. 79) There was no other documentation of any hospitalizations or emergency room visits.

Accordingly, the Department asserts that the determination to decrease Petitioner's PDN hours, based upon a review of the submitted recent medical documentation, is in accordance with the Medicaid Provider Manual policy. (Testimony of RN Medicaid Utilization Analyst)

Petitioner's father disagrees with the reduction. Petitioner's father testified that there are many instances they take care of things at home when they could have gone to a hospital and there are emergent situations at least twice a month. While an ambulance is called for the emergent situations, they get the child stable and do not go to the hospital because the children end up with more problems when they go to the hospital. Rather, they try to prevent hospitalizations, call the ambulance for assistance getting the child stable, and then have a doctor that comes to the house. Further, they cannot take one child to the hospital and leave the other child behind. (Testimony of Father) However, the submitted medical records, including the PDN provider records, do not show recurring emergent situations and ambulance calls. (Exhibit A, pp.16-133)

Petitioner's father testified that there have been additional hospitalizations. (Testimony of Father) However, the only documentation submitted that showed a recent hospitalization was the [redacted], planned admission for IV hydration prior to an MRI as discussed above. (Exhibit A, pp. 69-70 and 74)

Petitioner's father asserts that it is not fair to apply the PDN hour limitation rule for one child when there are two children. There are two children that need and qualify for PDN, therefore they should get 24 hours total, 12 hours for each child. (Testimony of Father) The RN Medicaid Utilization Analyst explained that nurses are trained to care for more than one patient at a time. The above cited Medicaid Provider Manual policy does indicate that there may be more than one beneficiary in the home receiving PDN services, so long as each beneficiary independently met the eligibility criteria for PDN and individual service logs are kept. Further, under section 1.13, Caring for More Than

One Patient at a Time, it is only ratios of more than two patients per nurse that are considered exceptional cases and require prior approval.

Petitioner's father also noted the policy for the exception process. However, under 2.5 Exception Process, exceptions are time limited and can only be considered in very limited circumstances. For example, if the basis for the exception is a temporary alteration in the beneficiary's care needs following a hospitalization, at least one of the two additional criteria must be met and the increase in PDN hours cannot exceed 2 hours per day for a maximum of six months. The other basis for an exception relates to an inability of the primary caregiver(s) to provide required care, such as an acute illness of the caregiver(s), death of the caregiver(s), or the home environment being unstable.

Petitioner's father is commended for being a strong advocate for his children and trying to ensure they have all needed medical services they are eligible for. However, based on the documentation submitted to the Department, the determination to reduce Petitioner's Private Duty Nursing (PDN) hours was in accordance with Department policy. The submitted medical records only documented one planned hospital admission for IV hydration prior to an MRI. The submitted documentation did not show any other hospitalizations or emergency room visits within six months of the [redacted], determination and did not support Petitioner's father's testimony of recurring emergent situations. The Medicaid Provider Manual Policy indicates there may be more than one beneficiary in the home receiving PDN services and a ratio of two patients per nurse is not an exceptional case. Lastly, exceptions for hours beyond the benefit limitations are to be time limited and only apply to specific circumstances.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the determination to reduce Petitioner's Private Duty Nursing (PDN) hours was in accordance with Department policy.

IT IS, THEREFORE, ORDERED that:

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

Colleen Lack

CL/cg

Colleen Lack
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

Agency Representative [redacted]

Petitioner [redacted]

Authorized Hearing Rep. [redacted]

DHHS Department Rep. [redacted]

DHHS -Dept Contact [redacted]