RICK SNYDER
GOVERNOR

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

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: June 30, 2016
MAHS Docket No.: 16-004847
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

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 June 23, 2016. Petitioner was represented at the hearing by Attorney Thomas V. Trainor (P30520). Petitioner did not appear to testify. Petitioner's Father, [redacted] and Grandmother, [redacted] appeared to testify on behalf of the Petitioner. Theresa Root, Appeals Review Officer and Kathy Action, Medicaid Utilization Analyst appeared to testify and represent the Department of Health and Human Services (Department or State or MDHHS).

State's Exhibit A pages 1-101 were admitted as evidence.

Petitioner's Hearing Summary was submitted on June 29, 2016. The Hearing Record closed on June 29, 2016.

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. Petitioner is a Medicaid beneficiary, date of birth [redacted].

2. Petitioner had a Plan of Care (POC) which expired on January 20, 2016.

3. On February 11, 2016, Generations Home Care Group sent Petitioner a letter requesting additional medical documentation in the form of an

updated Plan of Care; and Nursing Assessment which was less than 60 days old for the months of January or February; Inpatient/ER (or other significant medical) events, or acute physician visit(s); Admission history and Physical Report(s), discharge summary(ies), Results of Routine physician visits, planned medical visit/tests (i.e. vent clinic, etc.); test results (i.e. bronchoscopy, sleep study, etc.); and beneficiary's school schedule including travel time (i.e. number of hours per day & number of days per week). (State's Exhibit A page 7)

4. Petitioner is diagnosed with malignant neoplasm of brain, unspecified, obstructive hydrocephalus, congenital malformation of esophagus, unspecified tracheostomy complication, unspecified sequelae of unspecified cerebrovascular disease/neuromuscular disorder after brain tumor removal. (State's Exhibit A page 76)

5. Petitioner lives with two adult family members (Her father and her grandmother who assist in providing her care).

6. On March 16, 2016, the Department received a Plan of Care for Petitioner from Generations Home Care Group, date February 18, 2016. (State's Exhibit A pages 23 -26)

7. On March 17, 2016, Generations Home Care Group sent Petitioner a second letter stating that the Supervisor Nursing Assessment was greater than 60 days old and requesting updated information. (State's Exhibit A page 9)

8. On August 8, 2016, the Department sent Petitioner a Notification of Transitional Reduction of private duty nursing services stating that the denial was made because no documentation submitted of any ER visits or hospitalizations over the past six months after multiple requests, both verbally and in writing. School attendance of 40 hours per week. The reductions were as follows: Maintain 10 hours a day February 1, 2016 through April 30,2016; 8 hours a day from May 1, 2016 through September 30, 2016.(State's Exhibit A page 11)

9. On April 18, 2016, the Michigan Administrative Hearings System received a Request for Hearing to contest the reduction of Petitioner's Private Duty Nursing (PDN hours).

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 Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

The Medicaid Provider Manual (MPM) states in pertinent part:

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 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.

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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.

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

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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 MDHHS.

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, MDHHS will not reimburse the provider for services provided and billed. To assure payment, the provider must verify beneficiary eligibility monthly at a minimum.

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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.
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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.

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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.

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Petitioner’s witness testified that the service agency, Generations Home Care Group, has not been providing approved care for his daughter during the week and has only been coming on weekends. The family was unaware of the lack of documentation until it received the reduction notice. The family is in the process of searching for and retaining another Home Care Provider for Petitioner.

In the instant case, evidence on the record indicates that an updated plan of care was not submitted to the Department from the Generation Home Care Group (service agency). The service agency was notified of the need for updated plan of service documents including. The service agency notified the Department that the father refused to give the service agency a copy of an e-mail (State's Exhibit A page 13).

Documentation in the file indicated that Petitioner was attending school for 40 hours per week and that very little PDN was being provided to Petitioner by the service agency. When determining how many hours of PDN a person may be authorized for the Department must take into consideration the hours that they attend school. Testimony on the record indicates that Petitioner attends school 40 hours per week. A beneficiary who attends school 25 or more hours per week, on average, with a medium intensity level of care should authorized for a maximum of 8 hours per day. MPM, Private Duty Nursing, Section 2.4, page 12.

This Administrative Law Judge finds that based on the evidence submitted, Petitioner failed to prove by a preponderance of evidence that the denial in PDN was improper at the time it was made. The Department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with Department policy when it denied Petitioner's application for Private Duty Nursing benefits based upon its determination that Petitioner did not provide sufficient evidence of medical necessity for the requested benefits. The Department's decision to reduce Petitioner's authorization for Private Duty Nursing must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Petitioner's request for PDN hours based on the available information.

IT IS THEREFORE ORDERED that:

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

LL/sb

Landis Lain
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

Authorized Hearing Rep.

[redacted]

Petitioner

[redacted]

DHHS Department Rep.

[redacted]
320 S. Walnut Street
Lansing, MI
48909

DHHS -Dept Contact

[redacted]
CCC Building
6th Floor
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48919

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