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: October 27, 2016
MAHS Docket Nos.: **16-003456**
16-004684
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

The two above-captioned matters are before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon the Petitioner's requests for hearing. At the request of the parties, the two matters were also consolidated.

After due notice, an in-person hearing was begun as scheduled on May 25, 2016. However, while the consolidated hearing proceeded for approximately two hours, it was not completed and the ALJ determined that it should be continued at a later date. The continued hearing was subsequently scheduled, with due notice, for June 20, 2016. However, it was also later adjourned and rescheduled twice. On August 30, 2016, the continued hearing was held and completed.

[redacted], Petitioner's mother, appeared and testified on Petitioner's behalf during the consolidated hearing. [redacted], Nurse Practitioner; [redacted] Clinical Social Worker; [redacted] Registered Nurse (RN); [redacted] RN and Nursing Supervisor at [redacted], Private Duty Nurse; and [redacted] Supports Coordinator; also testified as witnesses for Petitioner

[redacted], Appeals Review Officer, represented the Respondent [redacted] (DHHS or Department). [redacted], a Manager in the Program Review Division, testified as a witness for the Department.

Following the completion of the hearing, the record was left open at Petitioner's representative's request so that she could submit additional evidence. However, Petitioner's representative did not submit any additional evidence and instead filed a letter in which she explained why she was not submitting any additional evidence and reiterating the arguments she made during the hearing.

Accordingly, the only exhibits admitted into the record were the three exhibits admitted during the hearing:

Exhibit 1: Petitioner's Hearing Summary Packet dated May 16, 2016, pages 1-113
Exhibit A: Department's Hearing Summary Packet dated April 14, 2016, pages 1-103
Exhibit B: Department's Hearing Summary Packet dated May 17, 2016, pages 1-103

ISSUE

Did the Department properly deny Petitioner's request for additional 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 is a nineteen-year-old Medicaid beneficiary who has been diagnosed with, among other conditions, spinal muscular atrophy, type 2; neuromuscular scoliosis; restrictive lung disease; hypoxemia; lumbago; upper and lower extremity pain; restless leg syndrome; osteopenia; anxiety; depression; respiratory failures; hypovolemia with active loss of fluid; and hyperglycemia. (Exhibit 1, pages 56-57; Exhibit B, pages 10-11).

2. Due to her conditions and comorbidities, Petitioner requires tracheotomy and positive pressure ventilator support. (Exhibit B, page 16).

3. Due to her impairments and need for assistance, Petitioner has also been approved for Home Help Services (HHS) through the Department's Home Help Program. (Exhibit A, pages 88-89; Exhibit B, page 101-102).

4. Specifically, Petitioner was approved for 44 hours and 24 minutes per month of HHS for assistance with bathing, grooming, dressing, toileting, transferring, mobility, housework, laundry, meal preparation, eating/feeding, and suctioning. (Exhibit A, pages 88-89; Exhibit B, page 101-102).

5. Petitioner has also been receiving PDN services through the Department. (Testimony of Petitioner's representative; Testimony of Department's witness).

6. Prior to her turning [redacted] in [redacted], Petitioner received her PDN services through the [redacted]

[redacted] (CWP). (Testimony of Petitioner's representative; Testimony of Department's witness).

7. Through the CWP, Petitioner was authorized for 16 hours of PDN per day. (Testimony of Petitioner's representative; Testimony of Department's witness).

8. After Petitioner aged out of the CWP, her PDN services were authorized through the Department's Program Review Division. (Testimony of Petitioner's representative; Testimony of Department's witness).

9. Initially, Petitioner was approved for 10 hours per day of PDN through the Department's Program Review Division. (Testimony of Department's witness).

10. However, the Department also temporarily increased the authorization of PDN to 14 hours per day based on Petitioner's representative's statements regarding Petitioner's care needs and the amount of PDN Petitioner had previously been receiving under the CWP. (Testimony of Department's witness).

11. On or about January 22, 2016, the Department received a prior authorization request and supporting documentation submitted on Petitioner's behalf by [redacted], her PDN provider. (Exhibit A, pages 7-68).

12. In that request, Petitioner asked for 16 hours per day of PDN for Petitioner beginning February 1, 2016. (Exhibit A, pages 7-68).

13. As part of that request, Petitioner submitted a January 19, 2016 letter from [redacted], a Clinical Supervisor at [redacted], in which [redacted] stated in part:

> Not only is [Petitioner] suffering the effects of end stage SMA (Spinal Muscle Atrophy), she has also experienced changes to her care and medication Regime [sic]. They are currently titrating and changing her Psychotropic medications. [Petitioner has been experiencing more depression and suicidal ideations. She also suffers from extreme anxiety and hallucinations. Skilled nursing is required to assess when they should intervene with medications or when to help control her symptoms with prescribed relation and redirection techniques.

> [Petitioner] also has a recent diagnosis of severe osteopenia. She suffered a non-displaced fracture of her right leg as a result of a 1 person transfer. Her physician is requesting that 2 people be present for all transfers to prevent further injuries to [Petitioner] and her care givers.
>
> Her current plan of care has been updated to reflex [sic] her increase in skilled nursing care and needs that were not reflected in previous plans of care, as well as the new interventions that she is requiring based on her change in status.

Exhibit A, page 8

14. Petitioner also submitted a January 12, 2016 Memorandum regarding Petitioner's family situation; the fact that her mother/representative is her sole caretaker; and her representative's own health issues. (Exhibit A, pages 9-11).

15. Petitioner further provided a Home Health Certification and Plan of Treatment signed by Petitioner's representative on [redacted], and by [redacted] and the attending physician on [redacted]. (Exhibit A, pages 12-26).

16. The prior authorization request also included a [redacted] prescription regarding work restrictions for Petitioner's representative; a Daily Schedule of Medications; and a Daily Schedule for Petitioner and her representative. (Exhibit A, pages 31, 36, 38-41).

17. Petitioner further provided a [redacted] Assessment completed on [redacted] letter from a [redacted]. (Exhibit 1, page 12; Exhibit A, pages 27-30, 32).

18. In that letter, [redacted] wrote in part:

> [Petitioner] has been treated for multiple orthopedic injuries, most recently a right knee injury on [redacted] that occurred during a transfer. [Petitioner] had x-rays taken at that time that were negative for fracture but showed extensive osteopenia and muscle atrophy. She is being managed with the assumption that she has a non-displaced fracture.

Exhibit 1, page 12; Exhibit A, page 32

19. The letter also provided that:

> Due to her extensive osteopenia [Petitioner] is at high risk for additional injuries. She requires total care with all activities. It is recommended for her safety as well as the safety of her caregivers that 2 people be present during all transfers.

Exhibit 1, page 12; Exhibit B, page 10

20. The prior authorization request also included a December 24, 2015 letter from [redacted], M.D. and [redacted] (Exhibit 1, page 13; Exhibit A, page 33).

21. In that letter, [redacted] wrote in part that:

> When [Petitioner] turned 18 her hours of nursing care decreased to 10 hours per day. She lives with a single mother who is unable to provide the 24/7 care which [Petitioner] requires including frequent repositioning, suctioning, lifting, and transferring, as well as the administration of more than 16 daily medications by mouth, G-tube or inhalation.
>
> [Petitioner] is a disabled young adult with terrific potential for a satisfying and productive life for many more years. A minimum of 16 hours of nursing care per day is strongly recommended in order to prevent further complications.

Exhibit A, page 33

22. Similarly, the prior authorization included an undated letter from [redacted]. [redacted] and Nurse Practitioner (NP) [redacted], in which they wrote in part:

[Petitioner] has had a significant decline in the last 12 months. She has continued to suffer with sinusitis and has had multiple courses of antibiotics without resolution of her symptoms . . . [Petitioner] has a history of chronic methicillin resistant staph aureus infections in multiple by cavities . . . She also has a history of recurrent pseudomonal infections in multiple body cavities including her trachea . . .Due to the stress on her body from all these infections [Petitioner's] ventilator need has increased and she is utilizing the ventilator 18-24 hours per day.

* * *

[Petitioner's] daily care needs are complex and exhaustive. She requires 6 sessions of nebulize treatments followed by cough assist and vest therapy daily. She requires over 35 doses of medication daily. She requires gastrostomy tube feedings provided in pump in a continuous fashion. She requires very prudent positioning and repositioning to avoid paid and pressure on the sacral decubitus ulcer as well as range of motion therapies to prevent further contractures. During nighttime hours [Petitioner] requires a care a minimum of every 2 hours for repositioning, tracheal suctioning, and provision of breathing treatments. [Petitioner] also has a well-documented nocturnal oxygen need and during the night caregivers are required to titrate oxygen to keep saturations at 92% or above.

[Petitioner] requires skilled nursing care and assessment to assist the family and medical team to stabilize and/or resolve these active problems. Specifically [Petitioner] requires:

1. Skilled assessment of respiratory status and function specifically identifying areas of decreased air exchange and/or change in respiratory patterns to indicate possible infection recurrence.

2. Skilled assessment of pain severity and evaluation of effectiveness of pain medication and monitoring for side effects.

3. Skilled evaluation of medications- [Petitioner] has 22 medications with over 35 doses given daily. Medications are provided via gastrostomy tube, inhaled and topical. Skilled assessment is required to evaluate [Petitioner's] response and monitor for side effects and or drug interactions.

4. Skilled evaluation of skin specifically targeting pressure points for the management and prevention of decubitus ulcers.

Exhibit A, pages 34-35

23. Petitioner further provided a January 14, 2016 letter from [redacted] Ph.D. and Licensed Psychologist, in which [redacted] requested that the maximum nursing staff be provided to meet Petitioner's needs due to an exacerbation of Petitioner's psychiatric symptoms and a change in Petitioner's psychotropic medications. (Exhibit 1, page 15; Exhibit A, page 37).

24. Lastly, the prior authorization request included Extended Hour Nursing Flow Sheets and/or Nursing Hourly Narratives for the dates of [redacted]. (Exhibit A, pages 42-67).

25. On February 8, 2016, the Department sent written notice to [redacted] that PDN services had been approved for Petitioner as follows:

> •A continuation of the temporary increase from 10 hours per day to 14 hours/day is granted: effective 02/01-03/31/2016 the authorization will be at 14 hours/day to allow continued complete evaluation of required skilled and non-skilled care needs, as well as, evaluation of required documentation. Effective 04/01-06/31/2016 the authorization will then be at 12 hours/day.

> •Documentation of medical course/progress/status will be re-evaluated at next review for temporary increase for continuation/adjustment of the 12 hour per day level.
>
> *Exhibit A, page 70*

26. The notice also described what documentation and information must be included as part of the next renewal request. (Exhibit A, page 71).

27. On or about March 14, 2016, the Department received a prior authorization request submitted on Petitioner's behalf by [redacted] and requesting 24 hours per day of PDN services for Petitioner. (Exhibit A, pages 72-75).

28. That prior authorization request also included a March 11, 2016 letter from [redacted] regarding a back injury to Petitioner's representative and a need for skilled nursing 24/7 until the primary caregiver is cleared. (Exhibit A, page 73).

29. On March 29, 2016, the Michigan Administrative Hearing System received a request for hearing filed by Petitioner and her representative in Docket No. 16-003456. (Exhibit A, page 5).

30. In that request, Petitioner and her representative stated that, while Petitioner was currently receiving 14 hours per day of PDN, she meets all the criteria for receiving 16 hours per day of PDN and that extensive medical documentation from multiple physicians has been sent in supporting the need for 16 hours per day of PDN. (Exhibit 1, page 4; Exhibit A, page 5).

31. On March 30, 2016, the Department sent [redacted] written notice that it required additional information to process and review the request for an increase in services to 24 hours per day. (Exhibit A, pages 80-81).

32. That same day, it also sent [redacted] written notice that Petitioner's PDN hours were temporarily allowed to continue at 14 hours per day from April 1, 2016 to April 30, 2016, but that the hours would be reduced to 12 hours per day effective May 1, 2016. (Exhibit A, pages 83-84; Exhibit B, pages 5-6).

33. On April 20, 2016, the Michigan Administrative Hearing System received a request for hearing filed by Petitioner and her representative in Docket No. 16-004684. (Exhibit B, page 4).

34. In that request, Petitioner and her representative asserted that Petitioner had received another notice of reduction, but that, as Petitioner already had an administrative hearing pending, the Department cannot reduce her PDN services until that matter is resolved. (Exhibit B, page 4).

35. On May 2, 2016, the Department received another Prior Authorization Request submitted on Petitioner's behalf and requesting 16 hours per day of PDN. (Exhibit B, page 7).

36. In support of that request, Petitioner and [redacted] attached supporting documentation, including the January 11, 2016 letter from [redacted] that was part of an earlier request. (Exhibit B, page 10).

37. Petitioner also attached an April 21, 2016 letter from [redacted] and [redacted] in which they discussed why Petitioner does not have a sling under her during transfers. (Exhibit 1, page 9; Exhibit B, page 11).

38. Petitioner further provided an April 23, 2016 letter from [redacted] and NP [redacted] in which they again described Petitioner's daily care and concluded that Petitioner needs 16 hours per day of PDN. (Exhibit 1, pages 6-8; Exhibit B, pages 12-14).

39. In part, that April 23, 2016 letter stated:

> [Petitioner] requires skilled nursing care and assessment to assist the family and medical team to stabilize and/or resolve these active problems.
>
> Specifically [Petitioner] requires:
>
> 1. Skilled assessment of respiratory status and function specifically identifying areas of decreased air exchange and/or change in respiratory patterns to indicate possible infection recurrence.
>
> 2. Skilled assessment of pain severity and evaluation of effectiveness of pain medication and monitoring for side effects.
>
> 3. Skilled evaluation of medications- [Petitioner] has 22 medications with over 35 doses given daily. Medications are provided via gastrostomy tube, inhaled

> and topical. Skilled assessment is required to evaluate [Petitioner's] response and monitor for side effects and or drug interactions.
>
> 4. Skilled evaluation of skin specifically targeting pressure points for the management and prevention of decubitus ulcers.

Exhibit B, page 13

40. The prior authorization request also included an April 28, 2016 Memorandum from Petitioner's representative discussing the additional documentation she has submitted and why no additional medical information regarding Petitioner's representative would be submitted. (Exhibit B, page 15).

41. The prior authorization request further included notes from office visits with the [redacted] dated [redacted]. (Exhibit B, pages 16-44).

42. A [redacted] Certification from the [redacted] was also provided and it stated that:

> Primary issue is wound care to coccyx. Patient has a history of SMA with limited mobility. She requires tracheostomy and mechanical ventilation due to chronic respiratory failure. She has a history of frequent hospitalization and infection requiring antibiotics. She has had recurrent sinusitis and fracheitis. She has a non-blanchable 1 cm wound to the coccyx which is concerning for a pressure sore.
>
> I certify that, based on my findings, the following services are medically necessary home health services to provide the following care/treatments: Skilled Nursing wound care

Exhibit B, page 46

43. The prior authorization request also included a [redacted] Progress Note regarding the treatment of restless leg syndrome and an

[redacted] Healthcare Assessment performed by [redacted] (Exhibit B, pages 47-52)

44. Lastly, the prior authorization request included Extended Hour Nursing Flow Sheets and/or Nursing Hourly Narratives for the dates of [redacted]. (Exhibit B, pages 53-99).

45. On May 12, 2016, the Department sent Petitioner written notice that the request for an increase in hours had been denied because the submitted documentation did not support a medical need for the requested need. (Exhibit B, pages 8-9).

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 Petitioner's private duty nursing (PDN) services and, with respect to such services, the applicable version of the Michigan Medicaid Provider Manual (MPM) states:

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.

* * *

1.4 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.

* * *

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.

* * *

1.7 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., MDHHS Home Help Program) or other resources for hourly care (e.g., private health insurance, trusts, bequests, private pay).
>
> *MPM, January 1, 2016 version*
> *Private Duty Nursing Chapter, pages 1, 3-5, 7*

Moreover, with respect to determining the amount of hours of PDN that can be approved, the MPM states in part:

> **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 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 number of hours) 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/	INTENSITY OF CARE

RESOURCE CONSIDERATIONS		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	6-12	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.

* * *

2.5 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 . . .

MPM, January 1, 2016 version
Private Duty Nursing Chapter, pages 11-14

Here, it is undisputed that the Petitioner needs some PDN services and it is only the amount of hours authorized that is at issue. As discussed above, since the initial authorization of 10 hours per day of PDN services for Petitioner was temporarily increased to 14 hours per day of PDN services, Petitioner has repeatedly requested that her PDN services be increased while the Department has both repeatedly denied the requests and determined that Petitioner's services should be gradually reduced to 12 hours per day, though it has also maintained Petitioner's PDN services at 14 hours per day while these matters are pending.

In support of those decisions, [redacted] testified that the previous authorization of 14 hours per day of PDN services was based on Petitioner's representative's statements regarding Petitioner's care needs and the amount of PDN Petitioner had previously been receiving under the CWP, and that it was only meant to be a temporary authorization until more information was provided.

Ms. [redacted] also testified that Petitioner subsequently requested 16 hours per day of PDN services in a January 22, 2016 prior authorization request, but that the request was denied on February 8, 2016. Regarding that denial, [redacted] testified that, while Petitioner met the eligibility criteria for PDN services, the submitted documentation only demonstrated that she fell into the medium intensity of care category and, based on the Decision Guide used by the Department, she would only be approved for 12 hours per day of services. In particular, [redacted] noted that many of the tasks described in Petitioner's plan of care did not require skilled nursing services and the tasks that did, such as deep suctioning, were not being documented as completed hourly in the nursing notes. [redacted] also noted that the Department only looks at the nursing notes were submitted along with the prior authorization request and that she is not aware of other notes that may have been recorded on an I-Pad or elsewhere.

According to [redacted], due to additional requests for increased PDN services, including one for 24 hours per day of services and one for 16 hours per day of such services, in addition to a need for further information with respect to that second request, the Department extended the temporary approval of 14 hours per day of PDN

services. However, it also later denied the requests and again determined that only 12 hours per day of PDN services should be approved.

Regarding the May 12, 2016 notice of decision, [redacted] testified that, while the submitted documentation discussed Petitioner's health issues, the nurses' notes also showed that suctioning and vitals were only checked 1-2 times per shift; Petitioner was sleeping 15 hours per day; and that her oxygen saturation stable. According to [redacted] such care indicated that Petitioner falls into the medium intensity of care category and that no increase in hours was warranted. She also testified that, while the Department received documentation from Petitioner's doctors at the [redacted] recommending 16 hours per day of PDN, the physicians cannot dictate the number of hours approved and the Department's decision is instead based on all the documentation it received. Regarding that documentation, [redacted] further testified that everything the Department received is in its exhibits and that she is not aware of any assessment or involvement by a [redacted]. in this case. She did testify that the documentation did not show a decubitus ulcer, just a wound that was being watched, or any definitive finding of a fracture, though a doctor's letter did indicate that she was being managed with the assumption that she had a non-displaced fracture. [redacted] further testified that use of a pulse oximeter does not require a nurse, as anyone can turn it up and down pursuant to a written protocol, and that the submitted documentation showed Petitioner to be stable with her oxygen needs addressed. Similarly, she testified that the pain assessment described in the plan of care is just asking a question and responding with medications if appropriate. Additionally, she also testified that the respiratory assessments were not happening every hour; skin assessments are never done hourly, just when changing Petitioner; and that none of the submitted documentation showed a need for skilled nursing assessments, judgments or interventions at least one time each hour throughout a 24-hour period that would justify placing Petitioner in the High Intensity of Care Category and approving more hours. Regarding nursing care facilities, [redacted] further testified that there are 7 ventilation care units in the State that she is aware of and, if Petitioner needs more than 16 hours per day of PDN, they could provide it

In response, Petitioner's representative testified that the first appeal was in response to the February 8, 2016 notice denying Petitioner's prior authorization request for more PDN hours and that, while Petitioner's representative did briefly describe being the sole caregiver and having her own health issues, Petitioner needs 16 hours of PDN care based on Petitioner's own needs. Petitioner's representative also testified that Petitioner was receiving 16 hours of PDN through CWP and that they are asking that her services be reinstated in that amount. Regarding Petitioner's needs, her representative noted that Petitioner has serious medical conditions and that Petitioner is only alive because of tireless work and desire to live; it takes two people to transfer Petitioner; she is vent dependent; and that she has issues with sleep even with the vent. Petitioner's representative also testified that there have been many letters issued by Petitioner's doctors citing the need for increased hours.

Regarding the Department's decisions, Petitioner's representative argued that the award of hours is subjective and that the Department went too far back, as the January nursing notes it looked at are not currently relevant and the Department needs more current notes, especially since Petitioner's nurses have recently been retrained and Petitioner's health has only deteriorated since that time.

Regarding other services, Petitioner's representative testified that, while Petitioner was approved for HHS, she has not received any Community Living Supports or respite care services through her local [redacted]. According to Petitioner's representative, the [redacted] did try to get a respite worker who would not have been a nurse, but that the respite worker would have only been called in to help Petitioner's representative and not replace her.

Nurse Practitioner [redacted] testified that she works with home vent programs at the [redacted], where Petitioner receives care and is the sickest among her 200 patients. She also testified that Petitioner is seen every three months there and that [redacted] current impression is that Petitioner's health is declining and that she is still advancing in her condition in the past year. Regarding that deterioration, [redacted] noted that Petitioner was hospitalized in [redacted] and had skin breakdowns in [redacted], though she also conceded that all that occurred after the denials at issue in these cases. However, she did note issues with a fracture and decubitus ulcers in [redacted], which both occurred prior to the decisions at issue in these cases. [redacted] also opined both that Petitioner requires more than 14 hours per day of PDN services given her need for assessments for recurrent infections and meticulous care of skin and interventions, and that Petitioner is at risk without around-the-clock nursing. She further cited to the letters that she and a doctor wrote in [redacted] regarding updates to Petitioner's care and asserted that published medical literature provides that a patient such as Petitioner, with a home mechanical ventilation, required an awake and alert caregiver 24 hours a day, 7 days a week. With respect to any nursing care facilities, [redacted] testified that any vent-dependent care unit in a nursing home would only have 1 respiratory therapist for every 24 patients, and that such a ratio would not give Petitioner the care she needs.

[redacted] testified that she is a Clinical Social Worker at the [redacted] and that, while she had no real interaction with anyone regarding Petitioner's PDN, she knows that Petitioner's care needs are quite extensive and that Petitioner was getting 16 hours per day under CWP. She also conceded that different criteria may be used in this case than what was used in the CWP.

[redacted] testified that she is a registered nurse at [redacted]., an organization that contracts with [redacted], and that, while Petitioner does not receive care through the [redacted], she did a PDN assessment in [redacted], and recommended 16 hours per day of PDN in a worksheet she believes was shared with the Department. She also testified that, during

her assessment, she found a need for total care and noted a significant change in Petitioner's appearance, increased difficulties in speech, skin breakdowns, multiple infections, and a decline in Petitioner's use of hands. She further testified that Petitioner has high intensity of care needs given her multiple comorbidities, need for close monitoring of respiratory infections, drug control, and generalized edema. [redacted] also testified that Petitioner had no skin breakdowns until the most recent visit.

[redacted] testified that she supervises nurses who care for Petitioner through [redacted], and that she sees Petitioner herself once a month or as often as needed. [redacted] also testified that, the last two times she has seen Petitioner, Petitioner was extremely incapacitated, with breathing issues; difficulty speaking; skin infections; an infected in-grown toenail; a flat affect; and depression. [redacted] further testified that Petitioner needs as many nursing hours as she can get given that Petitioner takes medications that require the use of a nurse, though her mother has also been trained to provide them; it takes time to assist Petitioner due to her chronic pain and osteopenia; she requires skilled respiratory assessments every hour; there is an ongoing need for suctioning; a nurse must decide whether saline needs to be used; the nurses are frequently assessing for signs and symptoms of pneumonia, checking Petitioner's blood sugars, and monitoring her for signs and symptoms of aspiration; during feedings a nurse must decide whether to decompress or vent Petitioner's feeding tube; Petitioner requires seizure precautions; Petitioner has bowel issues and need assessments by a nurse to determine whether she needs mirolax, enema or something else; and all necessary skin assessments are best made by licensed nurse. [redacted] also noted that Petitioner's skin breakdowns are not new, but were found to be worse during the assessment in [redacted]. [redacted] further testified that transferring Petitioner requires two people; Petitioner has been hospitalized 4-5 times since [redacted]. and that information regarding hospitalizations would have been included in the information given to the Department; and that she is not a fan of nursing homes given their ratio of workers to patients.

Regarding the documentation of Petitioner's care, [redacted] testified that the tablet used by the nursing agency does not have enough room for all the interventions and, while narrative notes are better, it is very hard to capture everything that is going on. She also testified that she has retrained nurses in writing notes so that they are more thorough, and that she has noticed a difference in the last three months, though she also noted that writing notes takes time away from caring for Petitioner and caring for her makes it more difficult to accurately record notes. [redacted] further testified that she has been working with the Department's PDN program for 4 years; she works with other entities, like insurance companies; and that, while they all require documentation of care, some require less than others.

[redacted] testified that she has worked with Petitioner for 1.5 years as day nurse, with a typical week involving over 40 hours of work and a typical day including constant pain assessments, frequent repositioning, suctioning Petitioner, checking vitals every four hours, and constant medications. She also testified that Petitioner's condition has

changed since [redacted] started and that it is difficult to keep Petitioner up without medications; Petitioner is in more pain; she has more fluid in her lungs and secretions; and her use of oxygen is up, especially at nighttime. She further testified that she is not sure how many hours Petitioner sleeps, but that Petitioner was taking naps before and does not now, when she is [redacted] When questioned by the Department's representative about the lack of any oxygen use on [redacted], [redacted] also testified that she is not sure about that date, but that Petitioner's oxygen use and pain have increased since that time.

[redacted] testified that she is Petitioner's Supports Coordinator at the [redacted] and has known Petitioner since[redacted] She also testified that she knows Petitioner was getting 16 hours per day of PDN through the [redacted], with an occasional increase to 24 hours per day when Petitioner's mother had surgeries, but that she still tried to get Petitioner 2 hours per day of respite care services. [redacted] further testified that Petitioner's mother was agreeable to having a respite care worker, who would not to have been a LPN or RN, but the request was ultimately denied by the [redacted]. [redacted] also testified that she was involved in a conversation where Department suggested a nursing home placement, but that she feels nursing home is an inappropriate option for Petitioner.

Petitioner bears the burden of proving by a preponderance of evidence that the Department erred in deciding to deny her requests for additional PDN services. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Department's decisions in light of the information that was available at the time the decisions were made.

Here, given the available information and applicable policies, the undersigned Administrative Law Judge finds that Petitioner has failed to meet her burden of proof and that the Department's decisions must therefore be affirmed.

On or about January 22, 2016, the Department received a prior authorization request and supporting documentation submitted on Petitioner's behalf and requesting 16 hours per day of PDN for Petitioner beginning February 1, 2016. On February 8, 2016, the Department sent written notice that, while a continuation of the temporary increase from 10 hours per day to 14 hours per day was granted, Petitioner's approved PDN would be decreased to 12 hours per day on April 1, 2016. On March 29, 2016, the Michigan Administrative Hearing System received the request for hearing filed by Petitioner and her representative in Docket No. 16-003456 regarding that decision.

In support of the prior authorization request, Petitioner also submitted letters from medical providers discussing her need for PDN, including [redacted] letter regarding Petitioner's change in psychotropic medications, her leg fracture and need for two people each transfer; [redacted] letter about Petitioner's osteopenia and need for two people to transfer; [redacted] letter regarding Petitioner's exacerbation of psychiatric symptoms and a change in psychotropic medications; and [redacted] and NP [redacted] letter identifying a need for skilled assessments of Petitioner's respiratory status and function, pain severity, medications, medications, and skin assessments.

However, those letters are not specifically supported by documentation regarding Petitioner's actual care and say nothing about the frequency of assessments. Moreover, not all of the care cited in those letters suggest an additional need for skilled nursing. For example, even if a doctor states that it takes two people to transfer Petitioner, it is not clear why one of those two people has to be a nurse. Similarly, it is undisputed that only deep suctioning requires skilled nursing and Petitioner was authorized HHS for assistance with eating/feeding and suctioning

Regardless, as testified to by the Department's witness, the actual nursing notes submitted along with the prior authorization request do not document a high intensity level of care and that testimony is essentially undisputed. Instead, Petitioner's representative only testified that the notes of January of 2016 are outdated, while Ms. [redacted] agreed that the nurses had to be retrained on writing notes. However, the Department can only rely on what is submitted.

Identification of Petitioner's diagnoses and broad statements of her care needs are insufficient to demonstrate that Petitioner falls into the High Intensity of Care Category and should be approved for more hours, especially given that not all of the care needs identified in those broad statements are skilled nursing care and the actual notes of nursing care fail to reflect that Petitioner requires nursing assessments, judgments and interventions by a licensed nurse at least one time each hour throughout a 24-hour period. Accordingly, given the information submitted in the January 22, 2016 request, the Department properly denied Petitioner's request for additional PDN services at that time.

On March 14, 2016, the Department received another prior authorization request submitted on Petitioner's behalf, and requesting 24 hours per day of PDN services for Petitioner because her mother/primary caregiver suffered a back injury and was not cleared to care for Petitioner. On March 30, 2016, the Department sent written notices that it required additional information to process and review the request for an increase in services to 24 hours per day, but that Petitioner's PDN hours would be allowed to continue at 14 hours per day from April 1, 2016 to April 30, 2016, but that the hours would be reduced to 12 hours per day effective May 1, 2016. On April 20, 2016, the Michigan Administrative Hearing System received a request for hearing filed by Petitioner and her representative in Docket No. 16-004684, in response to that notice of decision.

However, while the timing of the request for hearing suggests that Petitioner was appealing the March 30, 2016, Petitioner's representative expressly stated during the hearing that they were not challenging any decision based on Petitioner's representative's medical conditions and that they were solely arguing that Petitioner's needs alone justified additional PDN services. Accordingly, the March 30, 2016 decision is not at issue in this case and will not be considered further.

On May 2, 2016, the Department received another prior authorization request and supporting documentation submitted on Petitioner's behalf and requesting 16 hours per day of PDN. On May 12, 2016, the Department sent Petitioner written notice that the request for an increase in hours had been denied because the submitted documentation did not support a medical need for the requested need.

Given the timing of the request and denial, which both occurred after the second and last request for hearing filed by Petitioner, the May 12, 2016 decision appears to be beyond the scope of these proceedings. However, both parties were prepared to address the decision during the hearing and did so. Accordingly, given that both parties addressed it and for the sake of judicial efficiency, the undersigned Administrative Law Judge will also address the May 12, 2016 decision denying Petitioner's request for an increase in PDN hours.

While there was some documentation regarding office visits in the third prior authorization request, the request once again lacks specific evidence suggesting that Petitioner requires nursing assessments, judgments and interventions by a licensed nurse at least one time each hour throughout a 24-hour period, and it instead relies on broad statements regarding care, unskilled or otherwise, that Petitioner needs. However, as discussed above, a mere identification of Petitioner's diagnoses and broad statements of her care needs are insufficient to demonstrate that Petitioner falls into the High Intensity of Care Category, especially given that, as credibly testified to by the Department's witness, the actual nursing notes submitted along with the prior authorization request still did not document a high intensity level of care. Accordingly, given the information submitted in the May 12, 2016 request, the Department properly denied Petitioner's request for additional PDN services at that time.

To the extent Petitioner's representative argues that the Department erred by failing to take into account additional evidence, that argument must also be rejected. As part of her exhibit, Petitioner attached an unsigned February 10, 2016 letter from [redacted] and [redacted] written in support of request for 16 hours per day of PDN, Exhibit 1, pages 10-12; the [redacted] PDN Eligibility Worksheet completed by CLS, Exhibit 1, pages 17-21; an[redacted] Home Health Certification and Plan of Treatment, Exhibit 1, pages 23-37; a charts of Hourly Inputs/Outputs and Blood Glucose Monitoring, Exhibit 1, pages 39-54; a list of medication times for [redacted], Exhibit 1, pages 59-63; and nursing notes from [redacted], Exhibit 1, pages 70-106. However, as discussed above, the undersigned Administrative Law Judge is limited to reviewing the Department's decisions in light of the information that was available at the time the

decisions were made and, in this case, the additional evidence cited by Petitioner was never submitted to the Department as part of the prior authorization requests and/or is outside of the relevant time frame. During the hearing, Petitioner's representative argued that some of that documentation, such as the [redacted] PDN Eligibility Worksheet by [redacted], had already been submitted to the Department and the record was left open so that Petitioner could submit evidence that the documentation was submitted. However, Petitioner did not do so and instead only argued that the Department has had the documentation for months while these matters have been pending, which is irrelevant to the decisions at issue in these cases.

Petitioner clearly has very significant health issues and requires an enormous amount of care. However, based on the applicable policies and the information submitted to the Department, it is also clear that the Petitioner falls into the Medium Intensity of Care Category identified in the MPM and that the Department properly denied the requests for additional PDN services. Accordingly, the Department's decisions are affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Petitioner's requests for additional PDN services.

IT IS, THEREFORE, ORDERED that:

The Department's decisions are **AFFIRMED**.

SK/tm

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

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]