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: February 9, 2017
MAHS Docket No.: 16-017625
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 January 25, 2017. [redacted], Petitioner's Authorized Hearing's Representative (AHR) and Legal Guardian, and [redacted], [redacted] appeared on behalf of the Petitioner. [redacted], [redacted]; [redacted] and [redacted] represented the Department of Health and Human Services (Department or State).

State's Exhibit A pages 1-64 were admitted as evidence.

ISSUE

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

FINDINGS OF FACT

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

2. Petitioner is diagnosed with: immobility due to requirement of frequent suctioning and oxygen. She requires a non-invasive ventilator/face mask at night, a regular nasal cannula during the day and does not require a tracheostomy.

3. On November 28, 2016, the Department sent Petitioner a Notification of Reduction of Private Duty Nursing (PDN) Services for a proposed reduction from ten hours per day to eight hours per day, effective January 1, 2017 through April

30, 2017. The reduction was based upon the fact that medical criteria for ten hours per day of PDN had not been met because: Petitioner had no hospital admits during the certification period; the Petitioner does not require ventilation during the waking hours; and Petitioner has no tracheostomy. (State's Exhibit A page 10)

4. On December 1, 2016, the Michigan Administrative Hearing System received a Request for Hearing to appeal the decision to reduce the number of PDN hours for Petitioner. (State's Exhibit A page 5)

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.

The Children's Special Health Care Services (CSHCS) is mandated by the Michigan Public Health Code, Public Act 368 of 1978, Part 58, children and youth with special health care needs (MCL 333.5801 – 333.5879), in cooperation with the federal government under Title V of the Social Security Act, Sec. 501. [42 U.S.C. 701] (a) 1 (D) and the annual Michigan Department of Health and Human Services (MDHHS) Appropriations Act. This makes CSHCS a separate program from Medicaid.

CSHCS identifies children with special health care needs when the child appears to have a condition that CSHCS may cover. CSHCS does not cover behavioral, developmental or mental health conditions. The child's pediatric subspecialist submits medical reports to CSHCS for determination of medical eligibility.

When the child does not have a pediatric subspecialist and there is no other option to obtain a medical report (i.e., private insurance, Medicaid, etc.), CSHCS pays for a diagnostic evaluation of medical conditions that are likely to be covered by CSHCS. The beneficiary may be diagnosed with a CSHCS covered condition, which is the first step toward CSHCS eligibility but is not the only criterion. The condition must also meet chronicity, medical severity criteria, and the need for treatment by a pediatric subspecialist before the beneficiary can be determined medically eligible for CSHCS. Unlike other programs, there are no financial criteria that would limit eligibility for CSHCS. Eligibility is determined based upon medical circumstances and not on financial circumstances. Medical eligibility (and allowable citizenship/permanent residency status) must be established by MDHHS before the beneficiary can enroll in CSHCS.

Once enrolled, CSHCS covers pediatric specialty medical treatment (adult specialty for the few enrolled adults) related to the qualifying condition. Care is limited to the qualifying diagnosis and related conditions.

Medical Provider Manual
Children's special Health Care Services
Page 1, January 1, 2017

The Medicaid Provider Manual defines the parameters a person must meet to qualify for Private Duty Nursing.

Section 1 – General Information

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 the Habilitation Supports Waiver (the Community Mental Health Services Program) and over 21 years of age, that program authorizes the
PDN services.

1.1 Definition of PDN

Private Duty Nursing is defined as nursing services for beneficiaries who require more individual and continuous care, in contrast to part-time or intermittent care, than is available under the home health benefit. These services are provided by a registered nurse (RN), or licensed practical nurse (LPN) under the supervision of an RN, and must be ordered by the beneficiary's physician. Beneficiaries requiring PDN must demonstrate a need for continuous skilled nursing services, rather than a need for intermittent skilled nursing, personal care, and/or Home Help services. The terms "continuous" and "skilled nursing" are further defined in the Medical Criteria subsection for beneficiaries under age 21.

Medical Provider Manual
Private Duty Nursing
Page 1, January 1, 2017

1.2 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. (page 2)

1.3 PRIOR AUTHORIZATION

PDN services must be authorized by the PRD, 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. (page 3)

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 POC that identifies and addresses the beneficiary's need for PDN. The PDN must be under the direction of the beneficiary's physician; the physician must prescribe/order the services. The POC must be signed and dated by the beneficiary's physician, RN (as described above), and by the beneficiary or beneficiary's parent/guardian. The POC must be updated at least annually or more frequently as needed based on the beneficiary's medical needs.

1.7 BENEFIT LIMITATIONS

The purpose of the PDN benefit is to assist the beneficiary with medical care, enabling the beneficiary to remain in their home. PDN is intended as a transitional benefit to support and teach family members to function as independently as possible. Authorized hours will be modified as the beneficiary's condition and living situation stabilizes or changes. A decrease in hours will occur, for example, after a child has been weaned

from a ventilator or after a long term tracheostomy no longer requires frequent suctioning, etc. 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. Substantial alterations to the scheduled allotment of daily PDN hours due to family choice (i.e., vacations) unrelated to medical need or emergent circumstances require advance notice to the PRD. The remaining balance of authorized hours will not be increased to cover this type of utilization. Authorized time cannot be carried over from one authorization period to another.

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).

PDN providers are encouraged to work with families to assist in developing a backup plan for care of their child in the event that a PDN shift is delayed or cancelled, and the parent/guardian is unable to provide care. The parent/guardian is expected to arrange backup caregivers that they will notify, and the parent/guardian remains responsible for contacting these backup caregivers when necessary. (Pages 7-8)

2.3 MEDICAL CRITERIA

To qualify for PDN, the beneficiary must meet the medical criteria of **either** I and III below **or** II and III below:

Medical Criteria I

The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

- Mechanical ventilation four or more hours per day, or assisted respiration does not automatically include ventilation through Bi-level Positive Airway Pressure (Bi-PAP) or Continuous Positive Airway Pressure (CPAP). Use of these devices to satisfy this criteria will be evaluated on a case-by-case basis; or
- Oral or tracheostomy suctioning 8 or more times in a 24-hour period; or

- Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
- Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
- Continuous oxygen administration, in combination with a pulse oximeter and a documented need for observations and adjustments in the rate of oxygen administration.

Medical Criteria II

Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments or interventions as described in III below, due to a substantiated progressively debilitating physical disorder.

- "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months;
- "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder;
- "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish such services and which are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- "Progressively debilitating physical disorder" means an illness, diagnosis, or syndrome that results in increasing loss of function due to a physical disease process, and that has progressed to the point that continuous skilled nursing care (as defined in III below) is required; and
- "Substantiated" means documented in the clinical/medical record, including the nursing notes.

For beneficiaries described in II, the requirement for frequent episodes of medical instability is applicable only to the initial determination of medical necessity for PDN. Determination of continuing eligibility for PDN for beneficiaries defined in II is based on the original need for skilled nursing assessments, judgments, or interventions as described in III below

Medical Criteria III

The beneficiary requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

- "Continuous" means at least once every three hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.
- Equipment needs alone do not create the need for skilled nursing services.
- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse.
- Skilled nursing care includes, but is not limited to, performing assessments to determine the basis for acting or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; injections; indwelling central venous catheter care; managing mechanical ventilation; oxygen administration and evaluation; and tracheostomy care. (Pages 10-12)

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

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.

Medium Category

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.

Low Category

Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.

Medicaid uses the "Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis" (below) to establish the amount of PDN that is approved. The Decision Guide is used to determine the appropriate range of nursing hours (prior authorized and billed in 15-minute increments) that can be authorized under the Medicaid PDN benefit and defines the "benefit limitation" for individual beneficiaries.

The Decision Guide is used by the authorizing entity after it has determined the beneficiary meets both general eligibility requirements and medical criteria as stated above. The amount of PDN (i.e., 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. (Pages 12-13)

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.

2.6 CHANGE IN BENEFICIARY'S CONDITION/PDN AS A TRANSITIONAL BENEFIT

Medicaid policy requires that the integrated 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 PRD, Children's Waiver, or Habilitation Supports Waiver) in writing. Changes such as weaning from a ventilator or tracheostomy de-cannulation 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. (Page 16)

The Department representative indicated that the decision to reduce PDN authorization from ten hours per day to eight hours per day was based upon an improvement in Petitioner's condition. Petitioner is off of the ventilation during all waking hours and has no tracheostomy. Petitioner had no hospital admits during the authorization period of [redacted]

Petitioner's AHR testified that Petitioner had been ill with pneumonia since [redacted] Petitioner has a very fragile immune system. She required four courses of steroids, along with antibiotics and increased breathing treatments (every two to four hours), with CPT vest and rigorous suctioning. The PDN staffing is able to give Petitioner the on-to-one care that she so desperately needs. The AHR has two other children who also have medical problems. PDN allows Petitioner to be treated at home, rather than at a hospital, because the AHR can call the doctor and give a licensed medical professional opinion as to the Petitioner's condition and often treat her at home. Her hospitalizations has diminished since she has been receiving [redacted] hours of PDN per week.

In the instant case, Petitioner meets Medical Criteria I: Petitioner does not have a tracheostomy; and requires a bypass CPAP machine at night which is a non-invasive

ventilator program. Petitioner meets Medical Criteria I. She requires nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours per day. The factor I – shows that Petitioner has two or more caregivers; one works or is in school full time or part time. The maximum hours per day for such a person with low resources consideration is four-six hours of PDN per day.

This Administrative Law Judge finds that Department policy allows that 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.

Furthermore, Medicaid policy requires that the integrated 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 PRD, Children's Waiver, or Habilitation Supports Waiver) in writing. Changes such as weaning from a ventilator or tracheostomy de-cannulation 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.

Petitioner’s condition has improved sufficiently to reduce her hours of PDN for the following reasons: She does not require invasive ventilation. She is off ventilation during all waking hours. She does not have a tracheostomy. Thus, she no longer meets the medical criteria or medical necessity for the reception of ten hours of PDN per day. The Department’s proposed actions must be upheld based upon the evidence contained in the record.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with Department policy, laws and regulations under the circumstances when it proposed to reduce Petitioner's Private Duty Nursing allotment because Petitioner's medical condition improved sufficient to justify the reduction.

IT IS THEREFORE ORDERED that

The Department's actions are **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

DHHS Department Rep.

[redacted]

[redacted]

[redacted]

DHHS -Dept Contact

[redacted]

[redacted]