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 15, 2017
MAHS Docket No.: 16-019520
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

The above-captioned matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.* It was originally scheduled with Petitioner's father as the named party after he filed a request for hearing. However, Petitioner's father had actually requested the hearing on behalf of his two minor daughters and, during the hearing itself, the undersigned Administrative Law Judge also determined that there should be two separate docket numbers and two separate decisions for Petitioner and her sister. Petitioner was subsequently assigned Docket No. 16-019520 PAC and her sister was assigned Docket No. 16-016713 PAC

The two cases were consolidated and heard together on January 12, 2017. [redacted], Petitioner's father, appeared and testified on Petitioner's behalf. [redacted] Appeals Review Officer, represented the Respondent Michigan Department of Health and Human Services (MDHHS or Department). [redacted] registered nurse (RN), testified as a witness for the Department. [redacted] and [redacted] were also present during the hearing.

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 an eight-year-old Medicaid beneficiary who has been diagnosed with Pompe disease; complex partial epilepsy; profound developmental delay; history of seizures; cardiomyopathy; chronic ventilator dependence, status post tracheostomy placement;

encephalopathy chronic; quadriplegia; and gastroesophageal reflux disease. (Exhibit A, pages 16-17, 39, 44, 54, 60, 63).

2. Beginning in 2010, Petitioner was approved for 16 hours per day of PDN services through the Department. (Exhibit A, page 126).

3. On January 5, 2016, the Department issued a Notice of Transitional Reduction of Private Duty Nursing Services to the Petitioner indicating that her PDN hours would be gradually decreased. (Exhibit A, page 126).

4. Specifically, Petitioner was to receive 16 hours of PDN per day from January 1, 2016, thru January 31, 2016; 14 hours of PDN per day from February 1, 2016, thru February 29, 2016; and 12 hours of PDN per day from March 1, 2016, thru June 30, 2016. (Exhibit A, page 126).

5. On January 22, 2016, Petitioner's representative appealed that determination on her behalf. (Exhibit A, page 126).

6. On April 14, 2016, Administrative Law Judge (ALJ) Colleen Lack held an administrative hearing with respect to Petitioner's appeal. (Exhibit A, page 125).

7. On April 20, 2016, ALJ Lack issued a Decision and Order affirming the Department's decision to gradually reduce Petitioner's PDN services to 12 hours per day. (Exhibit A, pages 125-141).

8. On May 18, 2016, Petitioner's representative requested a rehearing/reconsideration of that decision. (Exhibit A, page 143).

9. On June 7, 2016, Supervising Administrative Law Judge Marya Nelson-Davis issued an Order Denying Request for Rehearing/Reconsideration. (Exhibit A, pages 143-145).

10. In June of 2016, after initially attempting to request an increase in hours, but improperly completing the request form, Petitioner's nursing agency submitted a prior authorization request for a renewal of 12 hours of PDN per day for Petitioner. (Testimony of Petitioner's representative; Testimony of Department's witness).

11. On July 5, 2016, the Department issued a written Notice of Authorization to Petitioner indicating that Petitioner would continue to be approved for 12 hours per day of PDN. (Exhibit A, pages 112-113).

12. On or about September 8, 2016, the Department received a prior authorization request for an increase to 16 hours per day of PDN for Petitioner. (Exhibit A, pages 16-67).

13. Along with that request, the Department received a plan of treatment documenting the 12 hours per day of nursing care that Petitioner receives as well as a Nursing Assessment dated August 15, 2016. (Exhibit A, pages 17-33).

14. The documentation submitted along with that request also included an undated letter from Petitioner's mother's doctor stating that Petitioner's mother has been diagnosed with posttraumatic stress disorder (PTSD); her PTSD symptoms have only intensified since Petitioner's appeal was denied; and that more intensified stress will result if the nursing hours are not reinstated. (Exhibit A, pages 34-35).

15. Additionally, the prior authorization included medical records relating to a doctor's visit on [redacted], during which it was noted that Petitioner would undergo testing for a seizure disorder; a [redacted] doctor's visit during which it was noted that Petitioner had gone to the emergency room after having a seizure; a [redacted] doctor's visit for which Petitioner came in due to prolonged tachycardia and it was found that she had pneumonia; ultrasound and chest x-ray reports from [redacted]; a doctor's visit on [redacted] during which it was noted that Petitioner has had regression in gross motor skills and language since her seizures started in January of 2016; a doctor's visit on [redacted] during which it was noted that Petitioner last had a seizure the previous month; an [redacted] doctor's visit during which it was noted that Petitioner was progressing as scheduled, would continue with current treatment, and would be reevaluated in four-to-six months. (Exhibit A, pages 39-67).

16. On October 24, 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 hours. (Exhibit A, pages 14-15).

17. On November 17, 2016, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter. (Exhibit A, pages 5-13)

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 [CHANGE MADE 10/1/16]**
>
> 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 MDHHS Program Review Division (PRD) **(added 10/1/16)** 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 [CHANGE MADE 10/1/16]

PDN services must be authorized by the PRD, **(revised 10/1/16)** 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 PRD, **(revised 10/1/16)**, 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 PRD. **(revised 10/1/16)**

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 PRD **(revised 10/1/16)** 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 PRD **(revised 10/1/16)** and will be specific to each beneficiary based on several factors, including the beneficiary's medical needs and family situation.

MDHHS will not reimburse PDN providers for services that have not been prior authorized. All forms and documentation must be completed according to the procedures provided in this chapter. If information is not provided according to policy (which includes signatures and correct information on the MSA-0732, POC and nursing assessment), requests will be returned to the provider. Authorization cannot be granted until all completed documentation is provided to MDHHS. Corrected submissions

will be processed as a new request for PDN authorization and no backdating will occur. **(added per bulletin MSA 16-18)**

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 PRD. **(revised 10/1/16)** (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 POC **(revised 10/1/16)**. 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.

* * *

1.4.A. DOCUMENTATION REQUIREMENTS [CHANGE MADE 10/1/16]

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 POC **(revised 10/1/16)** signed and

dated by the ordering/managing physician, RN, and the beneficiary's parent/guardian. The POC must support the skilled nursing services requested, and contain dates inclusive of the requested authorization period. **(revised per bulletin MSA 16-18)**

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)

- If the beneficiary was hospitalized during the last authorization period, include documentation related to the PDN qualifying diagnosis/condition, i.e., all hospital discharge summaries, history and physical examination, social worker notes/assessment, consultation reports (pulmonary; ears, nose and throat [ENT]; ventilator clinic; sleep study; etc.), and emergency department reports (if emergency services were rendered during the last authorization period). **(revised per bulletin MSA 16-18)**

- Teaching records pertaining to the education of parents/caregivers on the child's care. **(added per bulletin MSA 16-18)**

- Other documentation as requested by MDHHS.

* * *

1.7 BENEFIT LIMITATIONS [CHANGE MADE 10/1/16]

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. **(added per bulletin MSA 16-18)** 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. **(added per bulletin MSA 16-18)**

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. **(added per bulletin MSA 16-18)**

* * *

1.13 CARING FOR MORE THAN ONE PATIENT AT A TIME [CHANGE MADE 10/1/16]

For ratios of more than two patients per nurse, the provider must contact the entity authorizing the beneficiary's PDN services: Children's Waiver (the Community Mental Health Services Program), Habilitation Supports Waiver (the Community Mental Health Services Program), Home and Community- Based Services Waiver for the Elderly and Disabled (MI Choice Waiver) or the PRD. (revised 10/1/16) These ratios are considered exceptional cases and require prior approval.

When two Medicaid beneficiaries less than 21 years of age reside in the same home and require PDN services, one nurse will be authorized to provide care for both individuals. (The PDN rate is adjusted to accommodate this ratio.) In the event of an exceptional and emergent circumstance, a ratio of 1:1 nursing will be authorized for a limited period of time when two PDN beneficiaries reside in the same home. During this time period, PDN services must be reassessed on at least a monthly basis, documented in the POC, and submitted to the PDN authorizing entity to demonstrate the need for continuation of 1:1 nursing services. The POC must document efforts being made to wean the beneficiaries from 1:1 care. **(added per bulletin MSA 16-18)**

A PDN authorized to provide services to two children at the same location may find that, at times, only one child is present to receive services. This may occur when one child is in school, at a medical appointment, hospitalized, or on a family outing. The beneficiary record must document why only one child was present to receive services, as well as the beginning and ending time of the services. (Refer to the appropriate Billing and Reimbursement chapter for billing instructions.)

MPM, October 1, 2016 version
Private Duty Nursing Chapter, pages 1, 3-9
(Internal highlighting omitted)
(Underline added for emphasis)

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 [CHANGE MADE 10/1/16]**
>
> 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/ RESOURCE CONSIDERATIONS		INTENSITY OF CARE Average Number of Hours Per Day		
		LOW	MEDIUM	HIGH
Factor I – Availability of Caregivers Living in the Home	2 or more caregivers; both work or are in school F/T or P/T	4-8	6-12	10-16
	2 or more caregivers; 1 works or is in school F/T or P/T	4-6	4-10	10-14
	2 or more caregivers; neither works or is in school at least P/T	1-4	4-8	6-12
	1 caregiver; works or is in school F/T or P/T	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.

When using the Decision Guide, the following definitions apply:

- "Caregiver": legally responsible person (e.g., birth parents, adoptive parents, spouses), paid foster parents, guardian or other adults who are not legally responsible or paid to provide care but who choose to participate in providing care.

- "Full-time (F/T)": working at least 30 hours per week for wages/salary, or attending school at least 30 hours per week.

- "Part-time (P/T)": working at least 15 hours per week for wages/salary, or attending school at least 15 hours per week.

- "Significant" health issues: one or more primary caregiver(s) has a health or emotional condition that prevents the caregiver from providing care to the beneficiary (e.g., beneficiary weighs 70 pounds and has no mobility and the primary caregiver just had back surgery and is in a full-body cast).

- "Some" health issues: one or more primary caregiver(s) has a health or emotional condition, as documented by the caregiver's treating physician, that interferes with, but does not prevent, provision of care (e.g., caregiver has lupus, alcoholism, depression, back pain when lifting, lifting restrictions, etc.).

- "School" attendance: The average number of hours of school attendance per week is used to determine the maximum number of hours that can be authorized for the individual of school age. The average number of hours is determined by adding the number of hours in school plus transportation time. Authorization of PDN hours will not automatically be increased during breaks from school (vacations) or adjusted beyond the limits of factors I and II. **(revised per bulletin MSA 16-18)**

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

program) or when the child would typically be in school but for the parent's choice to home-school the child.

2.5 EXCEPTION PROCESS [CHANGE MADE 10/1/16]

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, October 1, 2016 version
Private Duty Nursing Chapter, pages 13-16
(Internal highlighting omitted)

Here, it is undisputed that the Petitioner needs some PDN services and it is only the amount of hours to be authorized that is at issue. While Petitioner was previously receiving sixteen 16 hours per day of PDN and wants to return to that amount, the

Department decided in January of 2016 to gradually reduce Petitioner's PDN services to 12 hours per day over the course of three months; its decision was upheld after Petitioner requested an administrative hearing; it reauthorized Petitioner for 12 hours per day of PDN in July of 2016; and it denied Petitioner's subsequent request for an increase.

In support of its most recent decision, the Department's witness described the history of Petitioner's PDN services and noted that there has been no significant change in Petitioner's conditions or needs since she was authorized for 12 hours per day in January of 2016 or July of 2016. In particular, the Department's witness testified that, while Petitioner continues to have significant medical issues, the documentation submitted along with the prior authorization request failed to reflect any significant decline and stated that Petitioner was progressing as expected. She further testified that the submitted documentation also continued to note that Petitioner has family and friends available to help her.

With respect to the documentation attached to the request for hearing in this case, the Department's witness denied receiving any such information prior to the decision being made in this case and she stated that she was unaware of any conversations Petitioner's representative may have had with other Department employees.

With respect to the documentation regarding Petitioner's mother that was included as part of the prior authorization request, the Department's witness testified that there was nothing in that documentation indicating why the health issues were affecting Petitioner's mother's ability to care for Petitioner and Petitioner's actual plan of care neither identified any caregiver issues nor explain how they were going to be addressed.

In response, Petitioner's representative testified that while he has had issues with the nursing provider, he assumed the letters from Petitioner's doctor and nurses attached to the request for hearing were previously submitted to the Department as part of the prior authorization request and they should therefore have already been in the system. He also noted that he himself tried to submit them to the Department later, but got no response

Regarding the new information, Petitioner's representative testified that the letters reflect a massive decline in Petitioner's health, including the development of seizures, and that Petitioner's new diagnoses are getting ignored by the Department. According to Petitioner's representative, Petitioner requires around-the-clock care, which her doctor would verify if called.

Petitioner's representative further testified that Petitioner's mother has PTSD and has had three panic attacks in the past four months, which negatively affects her ability to care for Petitioner and her sister. He also argued that the guidelines relied upon by the Department in this case should not apply because they are based on one beneficiary

while Petitioner and her sister both require PDN, which they receive on a 2:1 basis and which makes caring for them, whether it be by a nurse or a parent, more difficult.

Petitioner bears the burden of proving by a preponderance of evidence that the Department erred in deciding to deny her request 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 decision must therefore be affirmed.

Petitioner requested an increase during an authorization period and, per the above policy, she must therefore show a change in her condition that would warrant an increase, with the provider also reporting the change, the plan of care being updated, and the attending physician providing documentation that addresses the need for more hours. Here, Petitioner's representative does claim that there has been a massive decline in Petitioner's condition and an increase in her needs since the decision to reduce her services was made in January of 2016. However, the medical documentation submitted along with the prior authorization request failed to show any decline since the most recent authorization in July of 2016 as most of Petitioner's medical records predate that authorization; the plan of treatment only documents the 12 hours per day of services that Petitioner already receives, including her seizure care; and, as noted by the Department's witness, the most recent documentation indicated both that Petitioner was progressing as expected and that she would be reevaluated in four-to-six months.

Instead of pointing to the actual medical documentation submitted along with the request, Petitioner's representative points to letters from himself, Petitioner's doctors and Petitioner's nurses that he claims demonstrate Petitioner's decline and need for additional PDN services. 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, it does not appear that the additional evidence cited by Petitioner was ever submitted to the Department as part of the prior authorization request given the Department's witness' credible testimony and the fact that Petitioner's representative did not even provide all the documentation he claimed he did as part of the request for hearing. Moreover, even if considered, the identification of Petitioner's diagnoses and broad statements of her care needs in those letters are insufficient to demonstrate any change or need for additional services, especially given the specific information provided in the medical documentation submitted along with the prior authorization request.

Similarly, the documentation regarding Petitioner's mother's health status also failed to demonstrate a need for additional PDN hours. Given the amount of hours that have

already been authorized, Petitioner's mother would need to have "significant" health issues, and not just "some" health issue in order for her health issues to make a difference and significant health issues are only present where the caregiver has a health or emotional condition that "prevents" the caregiver from providing care to the beneficiary. However, in this case, there is no suggestion that Petitioner's mother's PTSD prevents her from caring for Petitioner or affects her ability to care for Petitioner at all and, instead, the undated doctor's letter merely states that Petitioner's mother's stress will increase if the additional hours are not granted.

Additionally, to the extent Petitioner's representative argues that the Department improperly failed to take into account the fact that Petitioner's sister also requires PDN, his argument must also be rejected pursuant to the above policy. As quoted above, the MPM expressly states that, when two Medicaid beneficiaries less than 21 years of age reside in the same home and both require PDN services, one nurse will be authorized to provide care for both individuals, with the PDN rate adjusted to accommodate that ratio, and there is no suggestion that such a situation warrants additional hours, especially where the Department's witness credibly testified that nurses are trained to care for more than one patient at a time.

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 Department properly denied the request for additional PDN services. Accordingly, the Department's decision 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 request 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 Department Rep.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]