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

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: March 24, 2017
MAHS Docket No.: 17-000068
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Colleen Lack

DECISION AND ORDER

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

After due notice, a hearing was held on February 22, 2017. [redacted], mother, appeared on behalf of the Petitioner. [redacted], Appeals Review Officer, represented the Department of Health and Human Services (Department). [redacted], Benefit Analyst, appeared as a witness for the Department. [redacted], Registered Nurse, was present as an observer.

During the hearing proceedings, the Department's Hearing Summary packet was admitted as Exhibit A, pp. 1-45, and the Department's addendum to their Hearing Summary packet was admitted as Exhibit B, pp. 1-40. The Department's objection to the admission of Petitioner's proposed exhibits (which included: two letters from Petitioner's primary care physician dated [redacted]; a CD of medical records from [redacted], where Petitioner's [redacted] hospitalization was; and a CD of radiology images from [redacted], where all images from the recent hospitalization and required follow-up studies are captured) was sustained because this information was not available to the Department when the written case action notice was issued on [redacted]. This Administrative Law Judge is limited to reviewing the Department's determination based on the information available to the Department at that time.

ISSUE

Did the Department properly determine Petitioner's Private Duty Nursing (PDN) services should be terminated?

FINDINGS OF FACT

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

1. The Petitioner is a [redacted]year old Medicaid beneficiary, date of birth [redacted], with diagnosis including microvillus inclusion disease, Broviac catheter, and total parenteral nutrition (TPN) dependence. (Exhibit A, p, 23)

2. Petitioner was approved for Medicaid-covered PDN services.

3. On [redacted], the Department received a prior authorization request for renewal of PDN services sent by Petitioner's PDN provider. The PDN provider requested 7 hours per day 5 days per week. In part, the submitted documentation indicated that Petitioner had not had any changes in condition, hospitalizations, consultations, or emergency visits; Petitioner generally attends school 7 hours per day 5 days per week, PDN is in the home about 5 hours in the evening after Petitioner returns home from school, or 8 hours per day when Petitioner is not in school; and the parents request no nursing on the weekends. A [redacted] note, in part, also states that the parents do not allow nursing staff to change or assess Petitioner's Broviac central line dressing; parents care for and change the central line dressing; parents care for Petitioner and complete all nursing tasks when nursing staff is not in the home; parents are trained to prepare TPN and administer medications; and Petitioner is able to communicate his needs. (Exhibit A, pp. 21-24; Exhibit B, pp. 1-40)

4. On [redacted], the Department issued a Notice of Reduction/Termination of Private Duty Nursing Services (Notice) to the Petitioner indicating that his PDN hours would be 8 hours per day from [redacted] through [redacted], then effective [redacted], PDN services will not be authorized. The Notice indicated the termination was based on a recent review of medical documentation and Petitioner not meeting PDN criteria. (Exhibit A, pp. 6-7)

5. On [redacted], the Petitioner's hearing request was received by the Michigan Administrative Hearing System. (Exhibit A, pp. 5-20)

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

The Medicaid Provider Manual addresses general information about PDN:

Private duty nursing (PDN) is a Medicaid benefit when provided in accordance with the policies and procedures outlined in this manual. Providers must adhere to all applicable coverage limitations, policies and procedures set forth in this manual.

PDN is covered for beneficiaries under age 21 who meet the medical criteria in this section. If the beneficiary is enrolled in or receiving case management services from the Habilitation Supports Waiver (the Community Mental Health Services Program) and over 21 years of age, that program authorizes the PDN services.

For a Medicaid beneficiary who is not receiving services from the Habilitation Supports Waiver (the Community Mental Health Services Program), the MDHHS Program Review Division (PRD) reviews the request for authorization and authorizes the services if the medical criteria and general eligibility requirements are met.

Medicaid Provider Manual,
Private Duty Nursing,
January 1, 2017, p. 1.

PDN services require prior authorization:

1.4 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.

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 the

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, 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.

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 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 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.

January 1, 2017, pp. 3-4.

The Medicaid Provider Manual addresses documentation requirements:

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 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, and contain dates inclusive of the requested authorization period.

  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 must be documented.
  - 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).

- Teaching records pertaining to the education of parents/caregivers on the child's care.
- Other documentation as requested by MDHHS.

Medicaid Provider Manual,
Private Duty Nursing,
January 1, 2017, pp. 5-6.

The Medicaid Provider Manual addresses benefit limitations:

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).
>
> Medicaid Provider Manual,
> Private Duty Nursing,
> January 1, 2017, pp. 7-8.

The Medicaid Provider Manual addresses medical criteria for PDN:

> **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.

Medicaid Provider Manual,
Private Duty Nursing,
January 1, 2017, pp. 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	**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	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	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.

chronic condition.	inability to communicate and direct their own care.	

Medicaid uses the "Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis" (below) to establish the amount of PDN that is approved. The Decision Guide is used to determine the appropriate range of nursing hours (prior authorized and billed in 15-minute increments) that can be authorized under the Medicaid PDN benefit and defines the "benefit limitation" for individual beneficiaries. The Decision Guide is used by the authorizing entity after it has determined the beneficiary meets both general eligibility requirements and medical criteria as stated above. The amount of PDN (i.e., the time) that can be authorized for a beneficiary is based on several factors, including the beneficiary's care needs which establish medical necessity for PDN, the beneficiary's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts, bequests, private pay). To illustrate, the number of hours covered by private health insurance is subtracted from the hours approved under Medicaid PDN. These factors are incorporated into the Decision Guide. The higher number in the range is considered the maximum number of hours that can be authorized. Except in emergency circumstances, Medicaid does not approve more than the maximum hours indicated in the guide.

Only those factors that influence the maximum number of hours that can be authorized are included on this decision matrix. Other factors (e.g., additional dependent children, additional children with special needs, and required nighttime interventions) that impact the caregiver's availability to provide care should be identified during an assessment of service needs. These factors have implications for service planning and should be considered when determining the actual number of hours (within the range) to authorize.

Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis

FAMILY SITUATION/ RESOURCE CONSIDERATIONS		**INTENSITY OF CARE Average Number of Hours Per Day**		
		LOW	**MEDIUM**	**HIGH**
Factor I – Availability of Caregivers Living in the Home	2 or more caregivers; both work or are in school F/T or P/T	4-8	6-12	10-16
	2 or more caregivers; 1	4-6	4-10	10-14

	works or is in school F/T or P/T			
	2 or more caregivers; neither works or is in school at least P/T	1-4	4-8	6-12
	1 caregiver; works or is in school F/T or P/T	4-8	6-12	10-16
	1 caregiver; does not work or is not a student	1-4	6-10	8-14
Factor II – Health Status of Caregiver(s)	Significant health issues	Add 2 hours if Factor I <= 8	Add 2 hours if Factor I <= 12	Add 2 hours if Factor I <= 14
	Some health issues	Add 1 hour if Factor I <= 7	Add 1 hour if Factor I <= 9	Add 1 hour if Factor I <= 13
Factor III – School *	Beneficiary attends school 25 or more hours per week, on average	Maximum of 6 hours per day	Maximum of 8 hours per day	Maximum of 12 hours per day

* Factor III limits the maximum number of hours which can be authorized for a beneficiary:

- Of any age in a center-based school program for more than 25 hours per week; or
- Age six and older for whom there is no medical justification for a homebound school program.

In both cases, the lesser of the maximum "allowable" for Factors I and II, or the maximum specified for Factor III, applies.

When using the Decision Guide, the following definitions apply:

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

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

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

Medicaid Provider Manual,
Private Duty Nursing,
January 1, 2017, pp. 12-14.

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 decannulation can occur after months or years of services, or a beneficiary's condition may stabilize to the point of requiring fewer PDN hours or the discontinuation of hours altogether. It is important that the provider report all changes resulting in a decrease in the number of hours to the authorizing agent as soon as they occur, as well as properly updating the POC. MDHHS will seek recovery of monies inappropriately paid to the provider if, during case review, the authorizing agent determines that a beneficiary required fewer PDN hours than was provided and MDHHS was not notified of the change in condition.
>
> In some cases, the authorized PDN services may be considered a transitional benefit. In cases such as this, one of the primary reasons for providing services should be to assist the family or caregiver(s) to become independent in the care of the beneficiary. The provider, in collaboration with the family or caregiver(s), may decide that the authorized number of hours should be decreased gradually to accommodate increased independence on the part of the family, caregiver(s), and/or beneficiary. A detailed exit plan with instructions relating to the decrease in hours and possible discontinuation of care should be documented in the POC. The provider must notify the authorizing agent that hours are being decreased and/or when the care will be discontinued.
>
> Medicaid Provider Manual,
> Private Duty Nursing,
> January 1, 2017, p. 16

In this case, the Department's determination to terminate PDN services for Petitioner was based on Petitioner not meeting PDN criteria following a review of medical documentation. (Exhibit A, pp. 6-7)

On [redacted], the Department received a prior authorization request for renewal of PDN services sent by Petitioner's PDN provider. The PDN provider requested 7 hours per day 5 days per week. In part, the submitted documentation indicated that Petitioner had not had any changes in condition, hospitalizations, consultations, or emergency visits; Petitioner generally attends school 7 hours per day 5 days per week, PDN is in the home about 5 hours in the evening after Petitioner returns home from school, or 8 hours per day when Petitioner is not in school; and the parents request no nursing on the weekends. A [redacted], note, in part, also states that the parents do not allow nursing staff to change or assess Petitioner's Broviac central line dressing; parents care for and change the central line dressing; parents care for Petitioner and complete all nursing tasks when nursing staff is not in the home; parents are trained to prepare TPN and administer medications; and Petitioner is able to communicate his needs. The Benefit Analyst testified that the nursing notes submitted with the renewal request did not document skilled nursing care. The Benefit Analyst also referenced several portions of the above cited policy, such as that Petitioner cannot

meet the criteria based on equipment needs alone and that PDN is intended as a transitional benefit to support and teach family members to function as independently as possible. Accordingly, the Department asserts that the determination to terminate Petitioner's PDN services is in accordance with the Medicaid Provider Manual policy as the submitted documentation did not indicate skilled nursing was required in the home. (Exhibit A, pp. 21-24; Exhibit B, pp. 1-40; Benefit Analyst Testimony)

Petitioner's mother disagrees with the termination and noted that she did not have any input regarding how the PDN provider presented the request. Petitioner's mother explained that Petitioner also has a personal nurse when he is at school. It was one of those nurses that caught the red flags for a central line infection, for which Petitioner was hospitalized in [redacted]. Petitioner's mother stated she can only monitor Petitioner's temperature, and not the other things the skilled nurses monitor, such as vitals, increased heart rate, open fill, etc. Petitioner is chronically ill, he has a genetic disease that will never go away. It was asserted that Petitioner is stable because of the skilled nursing, and it is nonsensical to take this away until he becomes critically ill. Petitioner's mother explained that they do not allow the nurses to care for the central line unattended because of a past incident with a nurse completing this care with fecal matter on her hands. Petitioner's mother was flabbergasted that the PDN nurses would state that they are not performing those duties. Rather, the parents are just trying to ensure as sterile conditions as possible when that care is provided. Petitioner's mother also indicated that the PDN provider would not have been aware of any consults because they would have been scheduled during the day, rather than during the time Petitioner has the PDN staff. Petitioner has six specialists he sees and they do not drag the nurses with them for these appointments. Petitioner's mother asserted that the information submitted gave an incomplete picture and that Petitioner does require skilled nursing. (Mother Testimony)

Petitioner's mother is commended for being a strong advocate for her son and trying to ensure he has all needed medical services he is eligible for. However, based on the documentation submitted to the Department for the PDN renewal request, the determination to terminate Petitioner's PDN services was in accordance with Department policy. The documentation submitted with the request for the renewal of PDN services did not establish that skilled nursing services were required in the home. Examples include the statements that the parents care for the central line and were not allowing nursing staff to change or assess the central line dressing, that the parents are trained to prepare TPN and administer medications, and that the parents provide all care on the weekends. Overall, the documentation submitted with this request supports the Department's determination to terminate Petitioner PDN services.

DECISION AND ORDER

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

IT IS, THEREFORE, ORDERED that:

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

CL/cg

Colleen Lack
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

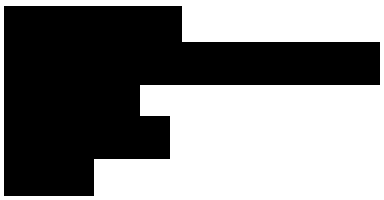
A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS Department Rep.



Petitioner

Agency Representative

DHHS -Dept Contact

Authorized Hearing Rep.