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: May 2, 2017
MAHS Docket No.: 17-002322
Agency No.: [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.*, and upon a request for hearing filed on the minor Petitioner's behalf.

After due notice, a telephone hearing was held on April 11, 2017. [redacted], Petitioner's mother, 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], a registered nurse (RN) and Medicaid Benefits Analyst, testified as a witness for the Department.

During the hearing, Petitioner did not submit any exhibits. The Department submitted one exhibit that was entered into the record as Exhibit A.

ISSUE

Did the Department properly reduce Petitioner's private duty nursing (PDN) services?

FINDINGS OF FACT

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

1. Petitioner is a two-year-old Medicaid beneficiary who has been diagnosed with chronic respiratory failure; dependence on a ventilator; and a history of congenital hypotonia and respiratory failure as a newborn. (Exhibit A, pages 8, 11).

2. Due to his medical conditions and need for nursing assistance, Petitioner was previously approved for 12 hours per day of PDN services through the Department. (Testimony of Department's witness).

3. On or about January 20, 2017, the Department received a request for a renewal of Petitioner's PDN services submitted on Petitioner's behalf by [redacted]. (Exhibit A, page 7).

4. Along with that request, [redacted] provided a Home Health Certification and Plan of Care; an Addendum to Plan of Treatment; a Comprehensive Assessment dated January 20, 2017; and Nursing Flow Sheets and Clinical Documentation. (Exhibit A, pages 8-54).

5. On January 30, 2017, the Department sent Petitioner written notice that, starting April 1, 2017, his PDN services would be reduced to ten (10) hours per day. (Exhibit A, page 5).

6. The notice also provided that the Department's decision was based on a recent review of the medical documentation submitted along with the prior authorization request, including the plan of care signed by Petitioner's parent and physician and nursing notes from the time period of December 12, 2016 to January 19, 2017. (Exhibit A, page 5).

7. On February 28, 2017, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding that determination. (Exhibit A, pages 4-6)

CONCLUSIONS OF LAW

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

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

> **SECTION 1 – GENERAL INFORMATION**
>
> This chapter applies to Independent and Agency Private Duty Nurses.
>
> Private duty nursing (PDN) is a Medicaid benefit when provided in accordance with the policies and procedures

outlined in this manual. Providers must adhere to all applicable coverage limitations, policies and procedures set forth in this manual.

PDN is covered for beneficiaries under age 21 who meet the medical criteria in this section. If the beneficiary is enrolled in or receiving case management services from 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.

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, Habilitation Supports Waiver, MI Choice Waiver).

1.1 DEFINITION OF PDN

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

* * *

1.4 PRIOR AUTHORIZATION

PDN services must be authorized by the 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.

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. (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. 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.

When a parent/guardian requests a transfer of care from one PDN provider to another, a completed MSA-0732 must be submitted to the PRD along with signed and dated documentation from the parent/guardian indicating that they are requesting a change in providers. The balance of hours authorized to a previous PDN provider will not be automatically transferred to a new provider. The new PDN provider is responsible for submitting the MSA-0732 to the PRD along with documentation from the parent/guardian requesting a new provider.

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

Other services provided in the home by community-based programs may affect the total care needs and the amount of PDN authorized. These other services must be disclosed on the MSA-0732 and documented in the POC. Although the amount of PDN authorized considers the beneficiary's medical needs and family circumstances, community-based services provided in the home are also part of this

assessment. Disclosure is necessary to prevent duplication of services to allow for an accurate calculation of authorized PDN hours. Providers are advised that failure to disclose all community resources in the home may be cause for recoupment of funds.

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

- 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.

* * *

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.

MPM, January 1, 2017 version
Private Duty Nursing Chapter, pages 1, 3-8

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

2.4 DETERMINING INTENSITY OF CARE AND MAXIMUM AMOUNT OF PDN

As part of determining the maximum amount of PDN a beneficiary is eligible for, his Intensity of Care category must be determined. This is a clinical judgment based on the following factors:

- The beneficiary's medical condition;
- The type and frequency of needed nursing assessments, judgments and interventions; and
- The impact of delayed nursing interventions.

Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary, but do not determine the number of hours of nursing for which the beneficiary is eligible.

High Category	Medium Category	Low Category
Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least 1 time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care

Medicaid uses the "Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis" (below) to establish the amount of PDN

that is approved. The Decision Guide is used to determine the appropriate range of nursing hours (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 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.

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

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 of family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status . . .

MPM, January 1, 2017 version
Private Duty Nursing Chapter, pages 13-15

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 12 hours per day of PDN and his representative asked to renew that amount, the Department instead decided in January of 2017 to reduce Petitioner's PDN services to 10 hours per day as of April 1, 2017.

In support of that decision, the Department's witness first described the documentation provided to the Department as part of the prior authorization request, with all such documentation being included in the Department's exhibit. In particular, she noted that the documentation provided that Petitioner's mother prefers that she, and not the nurses, perform Petitioner's daily tracheotomy care and any g-tube care; Petitioner had several days in the nursing notes where he had clear lung sounds, no cough, and no oral suctioning, and that much of the suctioning that Petitioner does receive is oral suctioning, which does not constitute skilled nursing. The Department's witness also noted that Petitioner had days where he did require deep trach suctioning, which does require skilled nursing, but that there was no documentation of any hospitalizations.

According to the Department's witness, based on the documentation submitted, Petitioner does not require a nursing assessment, judgment or intervention at least one time each hour throughout a 24-hour period and he therefore falls into the Medium Intensity of Care Category described in the above policy. She also testified that, in applying that Intensity of Care Category to the Decision Grid outlined in the MPM, along with Petitioner's Family Situation/Resource Considerations, where Petitioner has two caregivers, neither of whom has any health issues and where only one of them works or is in school full-time, the most PDN that Petitioner can receive is 10 hours per day of PDN, which is what he is authorized for. The Department's witness further testified that,

if Petitioner's condition worsened, then he can request additional PDN services if and when it becomes necessary.

In response, Petitioner's representative testified that she sees numerous issues when looking over the information submitted to the Department, with most issues being the fault of one particular nurse who was either not suctioning Petitioner when needed or not documenting all of the times he was suctioned. Petitioner's representative also testified that the notes not completed by that nurse, including the one regarding a day where Petitioner had deep trach suctioning 4 times, better document Petitioner's typical day, though she conceded that skilled nursing care was not needed every hour that day either. According to Petitioner's representative, Petitioner is stable and has improved overall, but he also goes through health cycles and is currently sick, during which time he requires nursing care every hour during the day. She also noted that Petitioner was hospitalized in December of 2016, February of 2017, and at other times in the past. Petitioner's representative further testified that the additional hours are needed for the times when Petitioner gets critical, especially given that his condition is so rare and he cannot express his needs.

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

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

The Department's witness credibly and fully described both the basis for the determination that Petitioner fell into the Medium Intensity of Care Category and the subsequent utilization of the Decision Grid found in policy to determine the number of hours that Petitioner should be approved. Moreover, while Petitioner's representative asserts that some of the information relied upon by the Department is inaccurate because of a nurse failing to provide necessary care or documenting what care was provided, the Department can only base its decision on what it has. Similarly, to the extent Petitioner's representative contradicts the Department's findings that Petitioner had not been hospitalized recently, her testimony must also be rejected as there was no documentation submitted regarding any hospitalizations and the most recent one, in February of 2017, occurred after the decision was made. Regardless, as noted by the Department's witness, Petitioner is already receiving the most PDN he can in light of his Intensity of Care Category and Family Situation, and the occasional hospital visit would not alter those factors. Petitioner's representative has failed to demonstrate that Petitioner falls into the High Intensity of Care Category and, while he clearly has significant health issues and requires an enormous amount of care, it is also clear that the Department properly decided to reduce Petitioner's PDN services given the applicable policies and the information submitted to the Department.

To the extent Petitioner's representative has additional or updated information to provide regarding the need for PDN, she can always have a new prior authorization request for additional hours submitted along with that information, and, if any future request is again denied, she can file another request for hearing. With respect to the issue in this case however, the Department's decision must be affirmed given the available information and applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly reduced Petitioner's 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]