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: August 10, 2017
MAHS Docket No.: 17-002395
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.*, and upon Petitioner's request for hearing.

After due notice, an in-person hearing was begun on April 25, 2017. However, the hearing was not completed during the scheduled time and the undersigned Administrative Law Judge determined that the hearing should be continued at a later date. Subsequently, and after an adjournment granted at Petitioner's request, the in-person hearing was continued and completed on June 14, 2017.

[redacted], an attorney with [redacted] represented Petitioner. Petitioner; [redacted], M.D. and Professor of Pediatrics; [redacted], Petitioner's father; and [redacted], Registered Nurse (RN) and Clinical Nurse Supervisor with [redacted].; testified as witnesses for Petitioner. [redacted], Petitioner's brother; [redacted], Petitioner's mother; and [redacted], one of Petitioner's nurses; were also present for one or both days of the hearing.

Assistant Attorney General [redacted] represented the Respondent Michigan Department of Health and Human Services (MDHHS or Department). [redacted], RN and Medicaid Benefits Analyst, testified as a witness for the Department.

At the onset of that hearing, the undersigned Administrative Law Judge denied Petitioner's previously-submitted Motion for Summary Disposition on the record and on the basis that there was a genuine issue of material fact in this case. The hearing then proceeded as scheduled.

During the hearing, Petitioner submitted eleven exhibits that were admitted into the record:

Exhibit 1: Medicaid Provider Manual (MPM), Private Duty Nursing (PDN), Section 2.3
Exhibit 2: MPM, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Section 1
Exhibit 3: MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, Section 17.3.B
Exhibit 4: MPM, School Based Services, Section 2.7
Exhibit 5: Adult Services Manual 101
Exhibit 6: Letter from [redacted], Pediatric Nurse Practitioner
Exhibit 7: Plan of Care
Exhibit 8: Notice of Action
Exhibit 9: Progress Notes
Exhibit 10: Nursing Notes
Exhibit 11: Letter from [redacted], RN

The Department submitted one exhibit that was admitted into the record:

Exhibit A: Hearing Summary/Evidence Packet

ISSUE

Did the Department properly decide to terminate 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 [redacted] Medicaid beneficiary who has been diagnosed with merosin-deficient muscular dystrophy; nocturnal hypoventilation; and oral phase dysphagia. (Exhibit 6, page 1).

2. Due to those conditions, Petitioner requires noninvasive positive pressure ventilator support and gastrostomy tube (G-tube) feedings at night. (Exhibit 6, page 1).

3. Petitioner has also been receiving 126 hours and 35 minutes per month of Home Help Services (HHS) through the Department for assistance with Activities of Daily Living and Instrumental Activities of Daily Living. (Exhibit A, page 163).

4. Fifteen minutes per day of the approved HHS is for specialized skin care assistance. (Exhibit A, page 163).

5. Petitioner's mother is his home help provider. (Exhibit A, page 163).

6. Petitioner has been approved for 60 hours per week of Community Living Supports (CLS) and 6 hours of respite care per week through the [redacted] Community Mental Health Authority as well. (Exhibit A, pages 26-29),

7. Through the Department, Petitioner has also been receiving 12 hours per day of PDN. (Testimony of Petitioner's father).

8. On or about February 14, 2017, the Department received a prior authorization request submitted on Petitioner's behalf by [redacted] the nursing agency who provides his PDN, for a renewal of the 12 hours per day of PDN. (Exhibit A, page 14).

9. Attached to that request was a Home Health Certification and Plan of Care in which it was indicated, among other things, that Petitioner is on a Bilevel Positive Airway Pressure (BiPAP) machine at night, for which he also wears a non-invasive mask, and that Petitioner receives oral suctioning through the use of a Yankauer device. (Exhibit A, pages 15-17).

10. The Home Health Certification and Plan of Care further provided that the nurse was to, among other things, observe and assess vital signs every shift and as needed; notify the doctor if those vital signs drop below specific levels; maintain Petitioner's oxygen saturation; maintain Petitioner's airway; keep Petitioner's skin intact; and maintain Petitioner's feeding tube. (Exhibit A, pages 15-17).

11. The prior authorization request's supporting documentation also included Petitioner's Individual Plan of Service (IPOS) with the [redacted] Community Mental Health Authority for the time period of [redacted] to [redacted], in which he was approved for CLS and respite care services; a document regarding Petitioner's daily routine at each of his parents' homes; and a document regarding the assistance provided by Petitioner's CLS staff that had been prepared by [redacted]. (Exhibit A, pages 21-29; Testimony of [redacted]

12. A letter from [redacted], a Pediatric Nurse Practitioner at the [redacted] Pediatric Ventilator Clinic within the [redacted] Children's Hospital was also attached and it stated in part:

> [Petitioner] wears a total face mask which covers the entire face for delivery of positive pressure ventilator support during times of sleep. The use of a total face mask places [Petitioner] at risk for aspiration from both routine oral secretions and any emesis that may occur. [Petitioner] requires skilled

> pulmonary assessment to evaluate for aspiration and overall pulmonary health. If a deviation from baseline is noted, nursing will contact the medical team for interventions.
>
> [Petitioner] has slow gastric mobility secondary chronic to immobility and muscular dystrophy. He requires skilled assessment of the toleration of tube feedings as well as abdominal assessment to manage constipation.
>
> Finally, [Petitioner is at risk for skin breakdown secondary to immobility. He requires skilled assessment of his skin with emphasis on pressure points, to evaluate for breakdown and implement a treatment to prevent development of decubitus ulcers.

Exhibit 6, page 1
Exhibit A, page 20

13. The documentation attached to the prior authorization request also included multiple progress notes regarding Petitioner's recent medical care. (Exhibit 9, pages 1-13; Exhibit A, pages 30-40).

14. A Progress Note dated [redacted] provided in part that Petitioner has been well since his last visit in April of 2016 and that Petitioner has been well since last visit in April of 2016, with Petitioner sleeping well, tolerating support, and having good energy throughout the day. (Exhibit 9, pages 11-13; Exhibit A, pages 40-42).

15. That Progress Note also stated:

> **Pulmonary:** [Petitioner] is currently at his baseline state of pulmonary health. There is no difficulty with coughing, wheezing, or change in nasal secretions. [Petitioner] is not on any respiratory regimen routinely. Family has albuterol, CoughAssist and a chest therapy vest that he uses only as needed when sick.

Exhibit A, page 40

16. A Progress Note dated [redacted] indicated that Petitioner has undergone a routine G-tube change after presenting with a leaky G-tube. (Exhibit 9, pages 1-4; Exhibit A, pages 30-33).

17. Another G-tube change was performed without complications on [redacted]. (Exhibit 9, pages 5-8; Exhibit A, pages 34-37)

18. A Progress Note dated [redacted] was issued after a repeat orthopedic evaluation and, in that note, Petitioner was described as "relatively healthy with no significant respiratory illnesses." (Exhibit A, page 38).

19. Patient Assessments and/or Clinical Notes completed by [redacted]., for [redacted] (Exhibit A, pages 65-66); [redacted] (Exhibit A, pages 70-71); [redacted] (Exhibit A, pages 67-68); [redacted] (Exhibit A, page 69); [redacted] (Exhibit A, pages 72-73); [redacted] (Exhibit A, page 74); [redacted] (Exhibit A, page 75-76); [redacted] (Exhibit A, pages 18-19, 77); [redacted] (Exhibit A, pages 78-79); [redacted] (Exhibit A, pages 80-81); [redacted] (Exhibit A, pages 82-83); [redacted] (Exhibit A, pages 43-45); [redacted] (Exhibit A, pages 46-47); [redacted] (Exhibit A, page 48); [redacted] (Exhibit A, page 49); [redacted] (Exhibit A, pages 50-51); [redacted] (Exhibit A, pages 52-56); [redacted] (Exhibit A, pages 57-58); [redacted] (Exhibit A, pages 59-62); and [redacted] (Exhibit A, pages 63-64); were also provided as part of the prior authorization request.

20. On [redacted], the Department sent Petitioner written notice that Petitioner would be authorized 12 hours per day of PDN from February 1, 2017 to March 31, 2017 and 8 hours per day of PDN from April 1, 2017 to April 30, 2017; but that PDN would not be authorized as of May 1, 2017. (Exhibit 8, pages 1-2; Exhibit A, pages 12-13).

21. The notice also provided that:

> This decision is based on a recent review of medical documentation from Plan of Care POC signed by parent and Physician, parent on [redacted] and physician on [redacted]. Current nursing notes [redacted]. This review indicates that a change in the authorized services is warranted because:
>
> - Based on the documentation provided beneficiary does not meet PDN criteria, has had no hospitalizations, on BIPAP only at night, and has sixty (60) hours of CLS per week, and works part-time. Please see the Medicaid Provider Manual, Private Duty Nursing Chapter, Section, 1.7 & 2.3.

- Based upon the submitted documentation, medical criteria for twelve (12) hours/day of PDN has not been met. Private Duty Nursing Chapter, Section 2.6 Change in Beneficiary's Condition/PDN as a Transitional Benefit.

- Other services may be an option for assistance to this beneficiary.

- The Children's Special Health Care Services Nurse in the beneficiary's county of residence may be able to assist the family in exploring/locating other services and/or other possible available options.

Exhibit 8, page 1
Exhibit A, page 12

22. On March 1, 2017, the Michigan Administrative Hearing System (MAHS) received the request for hearing filed in this matter regarding that determination. (Exhibit A, pages 7-11).

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.

* * *

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.

* * *

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.
>
> *MPM, January 1, 2017 version*
> *Private Duty Nursing Chapter, pages 1, 3-8, 10-11, 16*

Here, in response to a request for a renewal of 12 hours per day of PDN, the Department sent Petitioner written notice that Petitioner would be authorized 12 hours per day of PDN from February 1, 2017 to March 31, 2017, and 8 hours per day of PDN from April 1, 2017 to April 30, 2017; but that PDN would not be authorized as of May 1, 2017.

In support of that decision, the Department's RN testified that her duties include reviewing the prior authorization request and its supporting documentation and making a decision on that request based on the documentation and applicable policies. She also testified that it was her decision that Petitioner's PDN should be reduced and eventually eliminated. She also testified that, because her decision conflicted with the opinions of Petitioner's treating physician and nurse practitioner, the decision was reviewed by the Department's Office of Medical Affairs.

She further testified that she cannot speak to any past approvals made by other reviewers and that she is not aware of any major change or improvement in Petitioner's condition. The Department's RN also stated that PDN is a transitional benefit that is not intended to be permanent or to supplement Petitioner's other supports, and that its primary goal is to assist a beneficiary in being independent. She further testified that Petitioner has stabilized in this case, with no hospitalizations, frequent interventions, or adverse changes.

Regarding the request in this case, the Department's RN testified that the medical documentation and notes attached to the prior authorization request reflect that Petitioner receives wears a mask when using his BiPAP machine at night and receives assistance with oral suctioning and G-tube feedings. She also testified that such care does not constitute skilled nursing care. Specifically, she noted that, while suctioning is listed as skilled nursing in policy and that there is no distinction made between deep and oral suctioning, oral suctioning is not skilled nursing, as evidenced by the fact that it is being performed by Petitioner's parents and CLS workers. Similarly, while someone has to watch Petitioner during G-tube feedings, that person does not have to be a nurse and it is not skilled nursing to do so. The Department's RN likewise testified that the mask that Petitioner wears at night for his BiPAP is non-invasive and can be handled by a non-nurse.

The Department's RN further testified that, based on the information she received, Petitioner met Medical Criteria I because of his use of a BiPAP machine at night. She also testified that Petitioner did not meet Medical II Criteria given his stability, but that Medical Criteria II was irrelevant since he met Medical Criteria I and only needs to meet I and III to qualify for PDN services.

With respect to Medical Criteria III, the Department's RN concluded that Petitioner did not meet that specific criteria because he does not require continuous skilled nursing care on a daily basis. In particular, she noted that, while he needs a BiPAP machine at night, the above policy expressly states that those equipment needs alone do not create a need for skilled nursing services and that Petitioner does not receive other skilled care. As discussed above, she testified that the tasks being performed by the nurses, such as oral suctioning and g-tube changes, are not skilled care and can be performed by Petitioner's parents or other care providers through his other services, such as HHS or CLS services. She further testified that, while Petitioner has a lifelong condition, he has stabilized and is relatively healthy, to the point he is attending college, and that his stability also helps demonstrate that no continuous care is required and that any needs can be met by other supports and services.

In response, [redacted], Petitioner's treating physician at the Home Ventilator Clinic at the [redacted] since 2011, testified that Petitioner has chronic conditions and he is on a non-invasive ventilator at night because of muscle weakness and the risk of respiratory failure. [redacted] also testified that Petitioner progressed to a sip-and-puff ventilator six months ago and that the doctor prefers that a nurse, respiratory therapist or highly-trained parent manage the BiPAP

machine. According to [redacted], Petitioner's needs with respect to that machine are similar to anyone else on the machine, but also more critical for Petitioner.

[redacted] also testified initially that Petitioner is on a tracheostomy, but later confirmed that Petitioner is not and that he was thinking of Petitioner's brother, whom [redacted] also treats. The doctor further stated that he is very surprised that Petitioner has somehow avoided having a tracheostomy and that a small change, such as a cold, could cause Petitioner to require one. He also noted that Petitioner needs tube feedings, which can be problematic given that Petitioner is on a ventilator at the same time.

Petitioner's father testified regarding his understanding of Petitioner's condition and described it as a slowly progressing disease that affects all of Petitioner's functional abilities. He also testified that, because of that disease, Petitioner has required PDN for approximately five years. Petitioner shares the PDN with his brother and it is provided for 12 hours per day at night, which Petitioner's father describes as the most critical time.

Petitioner's father further testified that, in addition to PDN, Petitioner also receives CLS and respite through the local CMH and its self-determination program. He also noted that the family uses self-determination in order to make sure that Petitioner's needs are consistently met and that some potential providers have declined to work with Petitioner because of the level of care required. Petitioner also receives HHS that include specialized skin care.

Regarding PDN, Petitioner's father testified that he has never previously heard that it is a transitional benefit and that the nurses have not been training Petitioner's parents or other care providers as part of the nurses' duties. He also testified that he was surprised at the termination given the previous approvals; the lack of any changes, improvement or stability in Petitioner's condition; and Petitioner's steady decline over the years.

Petitioner's father further testified that Petitioner's G-tube feedings at night are supposed to be slow and continuous and provided while Petitioner sleeps, but it is very common that they have to be stopped because Petitioner has discomfort or nausea and that Petitioner has also had issues with G-tube leakage, which were brought to Petitioner's father's attention by Petitioner's nurses. Petitioner also requires oral suctioning during the day and night, which Petitioner's father has performed at times. Petitioner has not had any distress while using the BiPAP machine during the past six months that Petitioner's father is aware of, but Petitioner has vomited in the past while wearing the mask. Petitioner's father also testified that no respiratory therapist regularly checks on the ventilator and that they only have a telephone number to call if the equipment fails.

According to Petitioner's father, the Department erred by not completing an in-person assessment of Petitioner prior to deciding to terminate services and that the reports it

cited to as providing that Petitioner is doing well were all relative to Petitioner's baseline. He testified that the Department never requested additional information or clarification regarding the role of Petitioner's CLS workers, or anything else regarding Petitioner's needs, and that it improperly held Petitioner's goals and attendance at college against him. He also noted that he does not want to continue being forced to be a caregiver for Petitioner as that limits Petitioner's independence.

The Clinical Nurse Supervisor at [redacted]., testified that she has been working with Petitioner since September of 2016 and that the PDN is provided pursuant to a Plan of Care that is based on and in conjunction with the treating physician's orders. She also testified that the Plan of Care is reviewed every 60 days and the nurses are required to follow it.

She further testified that the nurses are also required to make assessments the beginning of their shift and then throughout the night and that, while they have not been specifically trained by the Department on how to write nursing notes, the nurses are told by their supervisor to document all skilled interventions and they were trained to document care as part of their education.

The Clinical Nurse Supervisor testified that she believes that Petitioner requires PDN and that the change from 12 hours per day of such services to no services is improper. In particular, she testified that the oral suctioning, G-tube feeding and ventilator care that Petitioner needs are all skilled interventions. She also testified that aides at his company are not permitted to do any suctioning, but that she is aware that Petitioner's parents perform oral suctioning as needed and that Petitioner's needs are being met by his parents and CLS workers when the nurses are not present. Overall, she believes that Petitioner needs both around-the-clock supervision by an awake and alert caregiver and occasional skilled care.

Petitioner himself testified that he feels safe with the nurses and that he recalls the care they provided when he vomited in his mask in the past. He also testified that he feels safe with his parents and the CLS workers, because his parents hired them, but that the CLS workers have never taken care of him while he is wearing a mask.

Petitioner bears the burden of proving by a preponderance of evidence that the Department erred in deciding to terminate 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 was made.

Given the available information and applicable policies in this case, 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.

As discussed above, to qualify for PDN, Petitioner must meet either Medical Criteria I and III, or Medical Criteria II and III. Here, it is undisputed that Petitioner meets Medical Criteria I, and he therefore only needs to meet Medial Criteria III in order to qualify for

PDN. As described above, to meet Medical Criteria III, a beneficiary must require continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services, with "continuous" defined as 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. Medical Criteria III also provides that equipment needs alone do not create the need for skilled nursing services.

Here, Petitioner's equipment needs alone do not establish that Petitioner meets Medical Criteria III and, as the record fails to reflect that any other skilled nursing is being provided, Petitioner does not meet Medical Criteria III. The primary skilled care identified by Petitioner is oral suctioning, but the undersigned Administrative Law Judge agrees with the testimony of the Department's witness that oral suctioning, as opposed to deep suctioning, is not skilled nursing. The Department's witness' testimony was credible and supported by the fact that oral suctioning is also being provided in this case by non-nurses, including both Petitioner's parents and his CLS workers. Moreover, while not approved as part of Petitioner's HHS, Adult Services Manual 101 (8-1-2016), page 3 of 5, expressly provides that suctioning is the type of care that can be approved as part of HHS and provided by a home help provider, who need not be a nurse.

Similarly, as credibly testified to by the Department's RN, other care being provided by Petitioner's nurses, such as G-tube feedings and skin care, also does not constitute skilled nursing care given who can and has been performing it.

Moreover, as properly testified to by the Department's witness, the current information submitted in support of the prior authorization request in this case is what is relevant and, even if a beneficiary like Petitioner has been authorized for PDN in the past and there is no evidence of significant improvement, that does not necessarily mean that PDN will be approved again.

Accordingly, while Petitioner clearly has significant health issues and requires an enormous amount of care, the record demonstrates that the Department properly decided to terminate Petitioner's PDN services given the applicable policies and the information submitted to the Department.

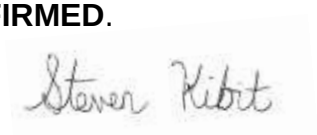
To the extent Petitioner's representative has additional or updated information to provide regarding the need for PDN, he can always have a new prior authorization request for hours submitted along with that information, and, if any future request is again denied, he can file another request for hearing. 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 decided to terminate Petitioner's PDN services.

IT IS, THEREFORE, ORDERED that:

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



SK/db

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

Agency Representative [redacted]

DHHS Department Rep. [redacted]

Counsel for Respondent [redacted]

Counsel for Petitioner [redacted]

Petitioner [redacted]

DHHS -Dept Contact [redacted]

DHHS-Location Contact [redacted]

Authorized Hearing Rep. [redacted]