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Date Mailed: June 14, 2021
MOAHR Docket No.: 21-002168
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

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 a request for a hearing filed on behalf of the minor Petitioner.

After due notice, a hearing was held on June 8, 2021. [redacted], Petitioner's mother and legal guardian, appeared on behalf of Petitioner. Tiffany Rickett, Clinical Supervisor from HeathCall, appeared as a witness for Petitioner. Allison Pool, Appeals Review Officer, appeared on behalf of the Respondent, Michigan Department of Health and Human Services. Mellody London, Medicaid Utilization Analyst appeared as a witness for the Department.

ISSUE

Did the Department properly authorize a reduction in 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 Medicaid beneficiary, born [redacted] 2002, who is diagnosed with microcephaly, severe developmental delay, refractory complex partial seizures, iron deficiency, apnea, GERD, and feeding intolerance. Petitioner has a tracheostomy, and g-tube. (Exhibit A, p 15,19; Testimony.)

2. In August 2020, Petitioner was hospitalized and received her first tracheostomy. (Testimony.)

3. In December 2020, Petitioner received an initial approval for 12 hours of PDN a day. The Petitioner qualified for PDN based on the tracheostomy. The initial 12-hour allocation was based upon the level of care required with an initial placement. The initial approval was to decrease to 10 hours of PDN a day effective March 28, 2021. (Exhibit A, p 28; Testimony.)

4. On March 25, 2021, HealthCall, submitted to Department, a reauthorization request for an increase in PDN hours from 10 hours to 12 hours per day. (Exhibit A, pp 28-124; Testimony.)

5. HealthCall's reauthorization documents reflected Petitioner's mother was a caregiver living in the home and not working or attending school. The documentation did not reflect any health issues belonging to Petitioner's mother. According to the documentation, Petitioner was hospitalized two times in the previous prior authorization period with hospitalizations on January 22, 2021 and March 14, 2021. Neither of the hospitalizations was related to Petitioner's tracheotomy. (Exhibit A, pp 28-124; Testimony.)

6. The nursing notes provided with HealthCall's reauthorization reflected Petitioner, on average, required 8-16 suctioning's per 12-hour shift and was stable on room air. (Exhibit A, pp 28-124; Testimony.)

7. On April 13, 2021, the Department sent Petitioner, a Notification of Denial of Private Duty Nursing Services Request for Administrative Hearing. The notification stated in part:

   - Based upon submitted documentation, medical criteria for increase to 12 hours has not been met. 10 hours of PDN will continue at this time.

   - Other services may be an option for assistance to this beneficiary. Contact DHS, CMH, and Children's Special Health Care Services Nurse in the beneficiary's County of residence. Family Center for Children and Youth with Special Health Care Needs 1-800-359-3722.[1]

8. In May 2021, the Michigan Office of Administrative Hearings and Rules received the request for hearing filed on behalf of the Petitioner. (Exhibit A, pp 6-14.)

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).

[1] Exhibit A, p 15.

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 the denial of a request for an increase in Petitioner's private duty nursing (PDN) services. 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 one of the above programs, the Program Review Division reviews the request for authorization and authorizes the services if the medical criteria and general eligibility requirements are met.
>
> For beneficiaries 21 and older, PDN is a waiver service that may be covered for qualifying individuals enrolled in the Habilitation Supports Waiver or MI Choice Waiver. When PDN is provided as a waiver service, the waiver agent must be billed for the services.
>
> Beneficiaries who are receiving PDN services through one Medicaid program cannot seek supplemental PDN hours from another Medicaid Program (i.e., Children's Waiver, Habilitation Supports Waiver, MI Choice Waiver).
>
> **1.1 DEFINITION OF PDN**
>
> Private Duty Nursing is defined as nursing services for beneficiaries who require more individual and continuous care, in contrast to part-time or intermittent care, than is

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

* * *

1.7 BENEFIT LIMITATION

The purpose of the PDN benefit is to assist the beneficiary with medical care, enabling the beneficiary to remain in their home. 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 hours 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 hours authorized for the month. The caregiver has the flexibility to use the monthly-authorized hours as needed during the month.

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., MDCH Home Help Program) or other resources for hourly care (e.g., private health insurance, trusts, bequests, private pay).

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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.

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

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

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

when determining the actual number of hours (within the range) to authorize.

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

FAMILY SITUATION/ RESOURCE CONSIDERATIONS		INTENSITY OF CARE Average Number of Hours Per Day		
		LOW	MEDIUM	HIGH
Factor I – Availability of Caregivers Living in the Home	2 or more caregivers; both work or are in school F/T or P/T	4-8	6-12	10-16
	2 or more caregivers; 1 works or is in school F/T or P/T	4-6	4-10	10-14
	2 or more caregivers; neither works or is in school at least P/T	1-4	4-8	6-12
	1 caregiver; works or is in school F/T or P/T	6-12	6-12	10-16
	1 caregiver; does not work or is not a student	1-4	6-10	8-14
Factor II – Health Status of Caregiver(s)	Significant health issues	Add 2 hours if Factor I <= 8	Add 2 hours if Factor I <= 12	Add 2 hours if Factor I <= 14
	Some health issues	Add 1 hour if Factor I <= 7	Add 1 hour if Factor I <= 9	Add 1 hour if Factor I <= 13
Factor III – School *	Beneficiary attends school 25 or more hours per week, on average	Maximum of 6 hours per day	Maximum of 8 hours per day	Maximum of 12 hours per day

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

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

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

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

Medicaid policy requires that the integrated plan of care (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 Program Review Division, 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. MDCH 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 MDCH 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.[2]

Petitioner bears the burden of proving by a preponderance of evidence that the Department erred in deciding to deny Petitioner's request for additional PDN services. For the reasons discussed below, this Administrative Law Judge finds that Petitioner has not met that burden of proof.

The Department's Medicaid Utilization Analyst (Department's Analyst) testified that a prior authorization request with supporting documentation was submitted by Petitioner's provider to renew Petitioner's PDN and request an additional 2 hours per day. The Department's Analyst indicated that Petitioner had been receiving 12 PDN hours per day as a result of receiving the initial trach placement in August of 2020. The Department's Analyst testified that following a review of Petitioner's prior authorization request and care records, the Department sent Petitioner and her provider written notice of a denial of the request for additional PDN services. The Department's Analyst testified that the decision was based on a review of medical documentation submitted from Petitioner's providers. The Department's Analyst testified that based on the records provided for review, Petitioner fell in the medium intensity of care level with 1 caregiver who did not attend school or work. This allocation permits an approval of between 6 and 10 hours per day. Furthermore, PDN is a transitional benefit per policy and that as a patient stabilizes, it should be expected that his or her PDN would decrease.

Based upon the medical documentation submitted, the Department properly determined that a denial of additional PDN was warranted. Petitioner has failed to meet her burden of proving by a preponderance of evidence that the Department erred in authorizing the reduction. Clearly, Petitioner has very significant health issues, requires an enormous amount of care, and Petitioner's Guardian should be commended for the constant care

[2] Medicaid Provider Manual, Private Duty Nursing, October 1, 2020, pp 1, 7-8, 10-13, 16.

that is provided. However, the documentation submitted did not indicate Petitioner as having a higher intensity of need or show that Petitioner's provider suffered from health issues of her own. Additionally, the current allotment of 10 hours falls within the appropriate range given the high intensity of care category that I believe Petitioner would fall in. Therefore, according to the information submitted, the Department's decision to deny additional PDN services should be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied a request for additional PDN services based on the medical records and nursing notes submitted.

IT IS THEREFORE ORDERED THAT:

Department's decision is AFFIRMED.

CA/dh

Corey Arendt
Administrative Law Judge
for Elizabeth Hertel, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

DHHS -Dept Contact

Gretchen Backer
400 S. Pine, 6th Floor
PO Box 30479
Lansing, MI 48909

DHHS Department Rep.

M. Carrier
Appeals Section
PO Box 30807
Lansing, MI 48933

Counsel for Petitioner

Allison Pool
MDHHS Appeals Section
PO Box P.O. Box 30807
Lansing, MI 48909

Petitioner

[redacted]
MI

Authorized Hearing Rep.

Hannah Leinonen
28000 Woodward
Royal Oak, MI 48067

Authorized Hearing Rep.

Tiffany Richett
28000 Woodward Ave
Royal Oak, MI 48067

Authorized Hearing Rep.

[redacted]
MI