Date Mailed: February 9, 2026
Docket No.: 26-001067
Case No.: [redacted]
Petitioner: [redacted]

DECISION AND ORDER

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

After due notice, a telephone hearing was held on February 4, 2026. [redacted], Petitioner's mother, appeared and testified on Petitioner's behalf. Leigha Klaver, Appeals Review Officer, represented Respondent, Michigan Department of Health and Human Services (MDHHS or Department). Mellody London, RN, Prior Authorization (PA) Private Duty Nursing (PDN) Reviewer, appeared as a witness for the Department.

ISSUE

Did the Department properly deny Petitioner's request for an increase in Private Duty Nursing (PDN) hours?

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] child with Trisomy 18, chronic lung disease, tracheobronchomalacia, and chronic respiratory failure requiring a tracheostomy and full-time ventilator support. She also has significant comorbidities including unrepaired cardiac defects with pulmonary hypertension, vein of Galen malformation, metabolic bone disease, and refractory epilepsy. (Exhibit A, pp 20–24; Testimony)

2. University of Michigan Pediatric Ventilator Clinic documented continuous ventilator dependence, seizure burden, and the need for hourly airway and pulmonary assessments, with oxygen saturation goals of ≥80% given cardiac physiology. (Exhibit A, pp 20–24; Testimony)

3. Petitioner currently receives 14 hours/day of PDN services authorized by MDHHS. On December 16, 2025, MDHHS issued a written denial of Petitioner's request to increase PDN to 16 hours/day, citing that the medical criteria in PDN Section 2.3 had not been met; the letter advised 14 hours would continue. (Exhibit A, pp 10–11; Testimony)

4. The denial letter also stated Petitioner's appeal rights and referenced 42 CFR 440.230(d) concerning the sufficiency of Medicaid services. (Exhibit A, p 11; Testimony)

5. In support of the increase, Petitioner submitted:

    a. A Centria Healthcare letter dated December 1, 2025, asserting the need to increase PDN hours to 16/day due to frequent seizures, complexity of trach/vent/G-tube care, and caregiver strain. (Exhibit A, p 42; Testimony)

    b. A completed MSA-0732 PDN prior authorization packet with care plan, nursing assessments, and the parent/legal guardian attestation reflecting high caregiver stress and competing family responsibilities. (Exhibit A, pp 24–36; 43–45; Testimony)

    c. Clinical records from the University of Michigan reflecting increased seizure activity, the cessation of ventilator weaning, and detailed hourly assessment needs in the home. (Exhibit A, pp 20–24; 36–40; Testimony)

6. The record contains multiple PDN shift notes from November 2025 documenting ongoing trach/vent care, suctioning, nebulizer treatments, G-tube feeds, safety measures, and seizure monitoring. Across representative dates, nurses recorded oxygen saturations typically ranging 82–93%, frequent secretion management, and brief seizures often lasting only a few seconds, with rescue medications infrequently required. (Exhibit A, pp 57–66; 68–76; 82–90; Testimony)

7. The PDN plan of treatment and addenda reiterate PDN as a transitional benefit, emphasize continuous skilled nursing where medically necessary, and note a requirement that a trained caregiver be awake, alert, and attentive 24 hours/day; the documents reference and incorporate PDN policy standards used by MDHHS in prior authorization determinations. (Exhibit A, pp 24–36; 42–50; Testimony)

8. The Medicaid PDN policy (as summarized in the record) specifies documentation requirements, intensity categories (including high-intensity care), and the expectation that family caregivers provide some of the daily care when medically safe. (Exhibit A, pp 104-121; Testimony)

9. Petitioner timely requested a hearing on January 6, 2026; MOAHR issued a Notice of Hearing for February 4, 2026, with instructions on participation and submissions. (Exhibit A, pp 2–5; Testimony)

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 the denial of additional 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 P(RD) 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. 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.

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.

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

Medicaid policy requires that the integrated POC be updated as necessary based on the beneficiary's medical needs. Additionally, when a beneficiary's condition changes, warranting a decrease in the number of approved hours or a discontinuation of services, the provider must report the change to the appropriate authorizing agent (i.e., the PRD, Children's Waiver, or Habilitation Supports Waiver) in writing. Changes such as weaning from a ventilator or tracheostomy decannulation can occur after months or years of services, or a beneficiary's condition may stabilize to the point of requiring fewer PDN hours or the discontinuation of hours altogether. It is important that the provider report all changes resulting in a decrease in the number of hours to the authorizing agent as soon as they occur, as well as properly updating the POC. MDHHS will seek recovery of monies inappropriately paid to the provider if, during case review, the authorizing agent determines that a beneficiary required fewer PDN hours than was provided and MDHHS was not notified of the change in condition.

In some cases, the authorized PDN services may be considered a transitional benefit. In cases such as this, one of the primary reasons for providing services should be to assist the family or caregiver(s) to become independent in the care of the beneficiary. The provider, in collaboration with the family or caregiver(s), may decide that the authorized number of hours should be decreased gradually to accommodate increased independence on the part of the family, caregiver(s), and/or beneficiary. A detailed exit plan with instructions relating to the decrease in hours and possible discontinuation of care should be documented in the POC. The provider must notify the authorizing agent that hours are being decreased and/or when the care will be discontinued.

Medicaid Provider Manual
Private Duty Nursing Chapter
October 1, 2025, pp 1, 7, 12-13, 16

In this case, there is no dispute that Petitioner meets the eligibility criteria for PDN; the issue is whether an increase from 14 hours of PDN services per day to 16 hours of PDN services per day is medically necessary.

The Department's witness testified that MDHHS denied Centria Healthcare's request to increase PDN hours from 14 to 16 per day because the submitted documentation did not meet Medicaid's medical criteria for such an increase. She reviewed the prior authorization forms and caregiver information, noting that the mother works part-time and reported high stress but that PDN policy does not authorize hours based solely on caregiver burden. London acknowledged that Petitioner qualifies for PDN services but emphasized that the question is whether the additional two hours are medically necessary.

The Department's witness highlighted the physician's letter and University of Michigan's statement recommending 16 hours due to Petitioner's complex needs, including ventilator and tracheostomy dependence and seizure disorder. However, she stated that nursing notes from November and December showed routine care—ventilator management, suctioning, and feeding—with minimal seizure activity documented. Most shifts recorded zero to three seizures, typically lasting only a few seconds, and rarely requiring rescue medication. The Department's witness concluded that the evidence did not demonstrate continuous instability or acute episodes warranting an increase beyond the current 14 hours. She also referenced Medicaid policy, which defines PDN as a transitional benefit intended to support family caregivers, not replace them, and requires documented medical necessity for any increase.

Petitioner's mother testified passionately about the challenges of caring for Petitioner. She explained that Petitioner's seizures are frequent – historically up to 27 per day and now averaging 11 daily – but often brief, lasting two to eight seconds, and therefore easily missed by nurses. She expressed frustration that nurses fail to document these episodes accurately, making the official records unreliable. Petitioner's mother described the overwhelming nature of her caregiving responsibilities, which include managing Petitioner's ventilator, tracheostomy, G-tube, medications, and monitoring for seizures, all while caring for other children and grandchildren. She emphasized that University of Michigan continues to recommend 16 hours of PDN and stated that the additional hours are not a luxury but a necessity for Petitioner's safety and her own ability to cope.

Petitioner's mother also shared the emotional toll, saying she feels like she is "begging" for help and that inconsistent nursing coverage – such as nurses calling off shifts – adds to her stress. She noted that some nurses lack adequate training, which forces her to intervene even during scheduled shifts. Despite these challenges, she affirmed her commitment to her daughter's care but urged that the system recognize the real-life demands beyond what is reflected in incomplete documentation.

Petitioner must prove, by a preponderance of the evidence, that the Department erred in denying the request for additional PDN. Having thoroughly reviewed the evidence, it is determined that Petitioner has failed to meet that burden.

The record establishes that Petitioner is medically fragile, ventilator dependent, and has a complex constellation of diagnoses and care needs. University of Michigan providers describe frequent seizures and the need for close monitoring and hourly assessments for airway, pulmonary status, gastrointestinal tolerance, skin integrity, and infection risk. (Exhibit A, pp 20–24)

Petitioner's caregiver attestation and Centria's letter further underscore significant caregiver stress and the family's desire for additional PDN support. (Exhibit A, pp 42–45)

However, PDN authorization determinations are governed not only by the presence of complex conditions but by whether the submitted documentation demonstrates the level and continuity of skilled nursing that exceeds the capacity of trained caregivers and that is medically necessary for the specific number of hours requested. The PDN policy places the burden on the provider to supply clear, contemporaneous evidence of continuous skilled interventions beyond unskilled support and to differentiate between routine, stable management versus acute medical instability warranting increased daily hours.

Here, Petitioner's PDN shift notes and care logs – while reflecting high-touch care – show that during the sampled periods in November 2025, Petitioner's oxygen saturations generally remained within the cardiology-directed goal range (≥80%), suctioning and respiratory treatments were delivered as scheduled or as needed, and seizures were frequently brief with infrequent need for rescue medication. These records describe regular, protocol-driven tasks that trained caregivers and licensed nurses perform, but they do not consistently demonstrate sustained, day-long episodes of acute instability or emergent interventions on a daily basis that would necessitate increasing PDN from 14 to 16 hours every day. (Exhibit A, pp 57–66; 68–76; 82–90)

Federal regulation 42 CFR 440.230(d) requires that Medicaid services be sufficient to meet medical needs but does not compel the authorization of additional hours absent proof that existing services are insufficient. The PDN policy – incorporated into the Plan of Treatment and provider documents – also describes PDN as transitional, contemplates family participation in care to the extent safe, and uses an intensity framework to align hours with documented medical necessity. On this record, MDHHS could reasonably conclude that the documentation supports continued 14 hours/day, which already covers substantial periods of licensed nursing alongside caregiver hours, and that the request for 16 hours/day was not medically justified under the PDN criteria presented.

Accordingly, applying the PDN Section 2.3 criteria to the evidence, and considering 42 CFR 440.230(d), the Department's denial is supported by the record and must be affirmed.

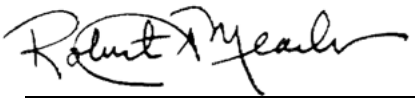
If Petitioner's actual care is different than what is being documented by the providers, the providers must document the actual care and submit a new request for additional PDN.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Petitioner's request to increase PDN hours from 14 PDN hours per day to 16 PDN hours per day based on the available information.

IT IS THEREFORE ORDERED that:

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



ROBERT J. MEADE
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to LARA-MOAHR-DCH@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

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