STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Docket No. 2012-26992 PCE

[redacted]

Appellant

_____/

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted]. The Appellant's daughter, [redacted], appeared on her behalf.

[redacted], [redacted] Quality Assurance Manager Registered Nurse, represented the Department's Program for All-Inclusive Care for the Elderly (PACE) waiver agency. [redacted], Care Resources Primary Care Physician, [redacted] Resources Executive Director, [redacted], Day Center Manager, [redacted] Occupational Therapist and [redacted], Physical Therapist were all present on behalf of the Waiver agent.

ISSUE

Whether the PACE organization properly denied coverage of a power scooter?

FINDINGS OF FACT

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

1. The Appellant is a Medicaid beneficiary who is enrolled in the Department of Community Health's Program for All-Inclusive Care for the Elderly (PACE).

2. Care Resources is the PACE organization in which the Appellant is enrolled.

3. The PACE program interdisciplinary team is responsible for determining necessary services for PACE Program participants.

4. The Appellant is a [redacted] year-old woman.

5. The Appellant resides in an apartment.

6. The Appellant is able to walk a few steps with use of a 4-wheeled walker. She is not functionally ambulatory and has a history of falls.

7. The Appellant has a manual wheelchair. She propels it independently.

8. The Appellant has had an electric scooter, which is now in disrepair. The scooter was not provided her through the PACE program as a benefit.

9. The Appellant participates in a day program outside of her home. While there she self propels in her manual wheelchair. She walks with aid of walker a few steps.

10. On [redacted], the Appellant made a request for a power scooter to the PACE program and seeks an electric scooter from the PACE program.

11. The Appellant was sent an Adequate Action Notice [redacted] and informed of appeal rights.

12. The Appellant requested an internal appeal of the determination. Following the internal appeal she was sent a second Adequate Action Notice on [redacted]. The Notice informed her that the item was "not a covered item that we provide."

13. The Appellant appealed the denial, requesting a formal administrative hearing [redacted]

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.

SECTION 1 – GENERAL INFORMATION

The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model of community-based care that enables elderly individuals, who are certified by their state as needing nursing facility care, to live as independently as possible.

PACE provides an alternative to traditional nursing facility care by offering pre-paid, capitated, comprehensive health care services designed to meet the following objectives:

- Enhance the quality of life and autonomy for frail, older adults;
- Maximize the dignity of, and respect for, older adults;
- Enable frail, older adults to live in the community as long as medically and socially feasible; and
- Preserve and support the older adult's family unit.

The PACE capitated benefit was authorized by the Balanced Budget Act of 1997 and features a comprehensive service delivery system with integrated Medicare and Medicaid financing.

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses beneficiary needs, develops a plan of care, and monitors delivery of all services (including acute care services as well as nursing facility services, when necessary) within an integrated system for a seamless provision of total care. Typically, PACE organizations provide social and medical services in an adult day health center supplemented by in-home and other services as needed.

The financing model combines payments from Medicare and Medicaid, allowing PACE organizations to provide all needed services rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems. PACE organizations assume full financial risk for beneficiary care without limits on amount, duration, or scope of services.

Physicians currently treating Medicaid patients who are in need of nursing facility care may consider PACE as an option. Hospital discharge planners may also identify suitable candidates for referral to PACE as an alternative to a nursing facility. (Refer to the Directory Appendix for PACE contact information.)

SECTION 2 – SERVICES

The PACE organization becomes the sole source of services for Medicare and Medicaid beneficiaries who choose to enroll in a PACE organization.

The PACE organization is able to coordinate the entire array of services to older adults with chronic care needs while allowing elders to maintain independence in the community

for as long as possible. The PACE service package must include all Medicare and Medicaid covered services, in addition to other services determined necessary by the interdisciplinary team for the individual beneficiary. Services must include, but are not limited to:

- Adult day care that offers nursing, physical, occupational and recreational therapies, meals, nutritional counseling, social work and personal care
- All primary medical care provided by a PACE physician familiar with the history, needs and preferences of each beneficiary, all specialty medical care, and all mental health care
- Interdisciplinary assessment and treatment planning
- Home health care, personal care, homemaker and chore services
- Restorative therapies
- Diagnostic services, including laboratory, x-rays, and other necessary tests and procedures
- Transportation for medical needs
- All necessary prescription drugs and any authorized over-the-counter medications included in the plan of care
- Social services
- All ancillary health services, such as audiology, dentistry, optometry, podiatry, speech therapy, prosthetics, **durable medical equipment**, and medical supplies (emphasis added by ALJ)
- Respite care
- Emergency room services, acute inpatient hospital and nursing facility care when necessary
- End-of-Life care

SECTION 3 – ELIGIBILITY AND ENROLLMENT

3.1 ELIGIBILITY REQUIREMENTS

To be eligible for PACE enrollment, applicants must meet the following requirements:

- Be age 55 years or older.
- Meet applicable Medicaid financial eligibility requirements. (Eligibility determinations will be made by the Michigan Department of Human Services.
- Reside in the PACE organization's service area.

- Be capable of safely residing in the community without jeopardizing health or safety while receiving services offered by the PACE organization.
- Receive a comprehensive assessment of participant needs by an interdisciplinary team.
- A determination of functional/medical eligibility based upon the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) that was conducted online within fourteen (14) calendar days from the date of enrollment into the PACE organization.
- Be provided timely and accurate information to support Informed Choice for all appropriate Medicaid options for Long Term Care.
- Not concurrently enrolled in the MI Choice program.
- Not concurrently enrolled in an HMO.

3.11 APPLICANT APPEALS

3.11.A. FINANCIAL ELIGIBILITY

A determination that an applicant is not financially eligible for Medicaid is an adverse action. Applicants may appeal to the Michigan Department of Human Services (MDHS). (Refer to the Directory Appendix for contact information.)

3.11.B. FUNCTIONAL/MEDICAL ELIGIBILITY

A determination that a beneficiary is not functionally/ medically eligible for PACE services is an adverse action. If the beneficiary and/or representative disagrees with this determination, they have the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found at the State Office of Administrative Hearings and Rules for the MDCH portion of the MDCH website. (Refer to the Directory Appendix for website information.)

3.11.C. PACE SERVICES

Noncoverage or nonpayment of services by the PACE organization for a beneficiary enrolled in PACE is an adverse action. If the beneficiary and/or representative disagrees with the noncoverage or nonpayment of services by the PACE organization, they have the right to request an administrative

hearing before an administrative law judge. Information regarding the appeal process may be found at the State Office of Administrative Hearings and Rules for the MDCH portion of the MDCH website. (Refer to the Directory Appendix for website information.) The beneficiary may request continuation of the disputed service with the understanding that he may be liable for the cost of the disputed service if the determination is not made in his favor.

Program of All-Inclusive Care for the Elderly
Version Date: April 1, 2012 Pages 1- 6

Medicaid beneficiaries are entitled to wheelchairs when medical necessity is established and standards of coverage are met. The Medicaid Provider Manual sets for the standards of coverage below:

2.47 WHEELCHAIRS, PEDIATRIC MOBILITY AND POSITIONING MEDICAL DEVICES, AND SEATING SYSTEMS

2.47.A. DEFINITIONS

Wheelchair A wheelchair has special construction consisting of a frame and wheels with many different options and includes, but is not limited to, standard, light-weight, high-strength, powered, etc.

Pediatric Mobility Product

Pediatric mobility products are pediatric-sized mobility and positioning medical devices (as defined by PDAC) that have a special light-weight construction consisting of a frame and wheels/base with many different options. Pediatric mobility devices include pediatric wheelchairs, transport chairs, hi/low chairs with outdoor/indoor bases, and standing systems designed specifically for children with special needs. These products must meet the definition of Durable Medical Equipment (DME) (refer to the Program Overview section of this chapter) and are not available as a commercial product or for which a commercial product can be used as an economic alternative.

Licensed Medical Professional

A licensed medical professional is defined as an occupational or physical therapist or a rehabilitation RN who has at least two years' experience in rehabilitation seating and is not an employee of the medical supplier. Medicaid policy requires that assessments must be performed by a licensed medical professional. A physical therapy assistant (PTA) or a licensed occupational therapy assistant (OTA) may not perform any part of the assessment or evaluation and may not complete or sign the MSA-1656.

Pediatric Subspecialist

A pediatric subspecialist is a physician who is board-certified in a pediatric subspecialty (such as a physiatrist, neurologist, or orthopedist). A pediatrician is not considered a pediatric subspecialist relative to this policy.

Institutional Residential Setting

An institutional residential setting refers to a nursing facility, hospital long-term care unit, or county medical care facility.

2.47 WHEELCHAIRS, PEDIATRIC MOBILITY AND POSITIONING MEDICAL DEVICES, AND SEATING SYSTEMS

2.47.A. DEFINITIONS

Wheelchair A wheelchair has special construction consisting of a frame and wheels with many different options and includes, but is not limited to, standard, light-weight, high-strength, powered, etc.

Pediatric Mobility Product

Pediatric mobility products are pediatric-sized mobility and positioning medical devices (as defined by PDAC) that have a special light-weight construction consisting of a frame and wheels/base with many different options. Pediatric mobility devices include pediatric wheelchairs, transport chairs, hi/low chairs with outdoor/indoor bases, and standing systems designed specifically for children with special needs. These products must meet the definition of Durable

Medical Equipment (DME) (refer to the Program Overview section of this chapter) and are not available as a commercial product or for which a commercial product can be used as an economic alternative.

Licensed Medical Professional

A licensed medical professional is defined as an occupational or physical therapist or a rehabilitation RN who has at least two years' experience in rehabilitation seating and is not an employee of the medical supplier.

Medicaid policy requires that assessments must be performed by a licensed medical professional. A physical therapy assistant (PTA) or a licensed occupational therapy assistant (OTA) may not perform any part of the assessment or evaluation and may not complete or sign the MSA-1656.

Pediatric Subspecialist

A pediatric subspecialist is a physician who is board-certified in a pediatric subspecialty (such as a physiatrist, neurologist, or orthopedist). A pediatrician is not considered a pediatric subspecialist relative to this policy.

Institutional Residential Setting

An institutional residential setting refers to a nursing facility, hospital long-term care unit, or county medical care facility.

2.47.B. STANDARDS OF COVERAGE

Manual Wheelchair in Community Residential Setting

May be covered if **all** of the following are met:

- Has a diagnosis/medical condition that indicates a lack of functional ambulatory status and ambulates less than 150 feet within one minute with or without an assistive medical device.
- Must be able to regularly use the wheelchair throughout the day.
- Must be able to be positioned in the chair safely and without aggravating any medical condition or causing injury.

- Purchase of a wheelchair is required for long-term use (greater than 10 months).

Must have a method to propel wheelchair, which may include:

- Ability to self-propel for at least 60 feet over hard, smooth, or carpeted surfaces.
- The beneficiary has a willing and able caregiver to push the chair if needed.

In addition:

A **standard hemi-wheelchair** may be covered when a lower seat to the floor is required.

A **standard light-weight wheelchair** may be covered when the beneficiary is unable to propel a standard wheelchair due to decreased upper extremity strength or secondary to a medical condition that affects endurance.

A **heavy-duty standard wheelchair** may be covered if the beneficiary's weight is more than 250 pounds but does not exceed 300 pounds.

An **extra heavy-duty standard wheelchair** is covered if the beneficiary's weight exceeds 300 pounds.

A **high-strength light-weight or ultra-light standard wheelchair** may be covered when required for a specific functional need.

A **back-up or secondary standard manual wheelchair** may be considered when:

- The beneficiary is primarily a power wheelchair user but needs a manual wheelchair to have access to the community or independent living.
- The beneficiary's medical condition requires a power wheelchair that cannot accommodate public transportation and, therefore, requires another transport device.

Manual Wheelchair with Custom-Fabricated Seating System in both Community Residential and Institutional Residential Settings

May be covered if **all** of the following are met, in addition to the Standards of Coverage listed under Manual Wheelchair in Community Residential Setting:

- Medical documentation provides a clinical assessment of the specific functional/clinical need for a custom-fabricated seating system. Documentation must specifically rule out other standard seating systems. The seating system must also meet standards of coverage.
- Must accommodate growth and adjustments for custom-fabricated seating systems a minimum of 3" in depth and 2" in width.
- Is an integral part of the care regimen in the community residential setting or the daily nursing plan of care in an institutional residential setting.

Power Wheelchair or Power-Operated Vehicle (POV) in Both Community Residential and Institutional Residential Settings

May be covered if the beneficiary meets **all** of the following:

- Lacks ability to propel a manual wheelchair, or has a medical condition that would be compromised by propelling a manual wheelchair, for at least 60 feet over hard, smooth, or carpeted surfaces with or without rest intervals.
- Requires use of a wheelchair for at least four hours throughout the day.
- Is able to safely operate, control and maneuver the wheelchair in their environmental setting, including through doorways and over thresholds up to 1½", as appropriate.
- Has a cognitive, functional level that permits safe operation of a power mobility device with or without training.
- Has visual acuity that permits safe operation of a power mobility device.
- For a three-wheeled power mobility device, has sufficient trunk control and balance.

Medicaid Provider Manual
Medical Supplier
Version Date: April 1, 2012 Pages 80-82

This ALJ reviewed the 2 notices sent the Appellant. They each indicate the requested item is not a covered benefit. This ALJ could not locate any support for that statement, or basis for denial. The Program requirements state it must offer the medical services available to Medicare and Medicaid beneficiaries and specifically states this is to include durable medical equipment. A manual or power operated wheelchair is durable medical equipment available to both Medicare and Medicaid beneficiaries if they meet the requirements. The Notices are not correct to simply indicate "not a covered item we provide."

At hearing, Care Resources cited the Appellant's ability to use her manual wheelchair inside of her home as a reason for denial. Evidence was presented she is able to propel her wheelchair without assistance at last evaluation. She is independent with her Activities of Daily Living. The Appellant does not make use of the housekeeping services offered through the program to assist with housekeeping. She attends her day program and self propels in her wheelchair there as well.

The Appellant's daughter served as hearing representative at hearing. She asserted her mother has to be pushed in her manual wheelchair now because she won't do it. She cited pain as the reason her mother won't self propel any longer. She stated her mother has to lean forward to self propel in her wheelchair and her back is sore. Also, she has had an ankle sprain, shoulder and neck pain. She stated she had a scooter before she even enrolled in the program but it no longer works and someone has to push her mother's wheelchair for her to go anywhere.

Care Resources countered that the Appellant has only participated in the physical therapy offered to address pain 2 times and thereafter cancelled and refused the treatment. Additionally, the Appellant self reported improvement in her pain management with medication. Evidence was provided indicating she had a mobility evaluation wherein she demonstrated ability to use the manual wheelchair for over 135 feet. It was asserted this is adequate for her to have in home mobility. It was asserted the mobility evaluation was for the purpose of determining in home ability and is not used to evaluate mobility needs for recreational purposes. (out in the community)

Turning to the criteria for provision of a power wheelchair, the standards of coverage indicate there must be a determination made the Appellant is not able to propel a manual wheelchair for at least 60 feet over a hard surface. This has not been established. The evidence of the Appellant's ability to propel a manual wheelchair presented by the Respondent is that she is able to do so at least 135 feet. This does not meet the criteria for provision of the item requested. This ALJ is sympathetic to the Appellant and her circumstance due to reports of shoulder, neck ankle and hip pain; however, she is bound to the written standards.

The Appellant failed to prove by a preponderance of evidence, that the PACE organization's actions were not in accordance with the applicable standards for coverage a power scooter.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the PACE organization's denial of a power scooter is was proper.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5-22-12

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.