

## ISSUE

Did Respondent properly deny Petitioner's request for a power wheelchair?

### *FINDINGS OF FACT*

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

1. Respondent is an organization that contracts with the Michigan Department of Health and Human Services ("MDHHS" or "Department") and oversees PACE in Petitioner's geographical area.
2. Petitioner has been enrolled in PACE and receiving services through Respondent. (Exhibit A, pages 6-12).
3. While at the PACE center, Petitioner has used a manual wheelchair by propelling himself. (Exhibit A, pages 6-12; Testimony of Petitioner; Testimony of PT).
4. Inside his home, Petitioner has been using a walker. (Testimony of Petitioner; Testimony of PT).
5. On or about April 23, 2020, Petitioner requested that Respondent provide Petitioner with a power wheelchair so that he could visit with friends nearby. (Exhibit A, page 6).
6. On April 24, 2020, Respondent sent Petitioner written notice that his request had been denied because it was inappropriate to his plan of care. (Exhibit A, page 4).
7. The notice of denial specifically noted that Petitioner can utilize his current equipment in his home and that he has demonstrated an ability to propel himself in his manual wheelchair. (Exhibit A, page 4).
8. On June 2, 2020, the Michigan Office Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner in this matter regarding Respondent's decision. (Exhibit A, page 5).

### *CONCLUSIONS OF LAW*

The Medical Assistance Program (MA) 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.

PACE services are available as part of the Medicaid program and, with respect to the program and its services, the Medicaid Provider Manual (MPM) provides:

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
- Respite care
- Emergency room services, acute inpatient hospital and nursing facility care when necessary
- End-of-Life care

*MPM, April 1, 2020 version  
PACE Chapter, pages 1-2*

Here, Petitioner has been approved for PACE services at all times relevant to this matter and it is only the denial of his request for a power wheelchair that is in dispute.

In appealing Respondent's decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information available at the time the decision was made.

Given the record and available information in this case, Petitioner has failed to meet his burden of proof and Respondent's decision must therefore be affirmed. It is undisputed that, while Petitioner has some limitations in mobility and was in physical therapy, he was using a walker in his home and a manual wheelchair outside of his home at the time the request was made. Accordingly, the requested power wheelchair was not needed or appropriate.

Moreover, while Petitioner credibly testified as to how his health condition has worsened since he was last seen by Respondent and he now cannot use his manual wheelchair at all, that worsening is a new development that is beyond the scope of this proceeding as the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information available at the time the decision was made.

To the extent Petitioner's circumstances have changed, he can always request a power wheelchair again in the future. With respect to the issue in this case however, Respondent's decision is affirmed given the information available at the time.

***DECISION AND ORDER***

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent's properly denied Petitioner's request for a power wheelchair.

**IT IS, THEREFORE, ORDERED** that:

Respondent's decision is **AFFIRMED**.