

ISSUE

Did Respondent properly deny Petitioner's request for a power scooter through the Program of All-Inclusive Care for the Elderly (PACE)?

FINDINGS OF FACT

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

1. PACE is an organization that contracts with the Michigan Department of Health and Human Services (MDHHS or Department) and oversees the PACE program in Petitioner's geographical area. (Exhibit A; Testimony).
2. Petitioner is an adult male who has been receiving services through PACE. (Exhibit A; Testimony).
3. In February 2023, PACE received a request from Petitioner for a power scooter. (Exhibit A; Testimony)

4. On February 21, 2023, PACE's occupational therapist (OT) completed a power scooter assessment with Petitioner. Following the assessment, PACE's OT recommended that Petitioner's request for a power scooter be denied. Specifically, PACE's OT concluded:

This writer recommends denial of Power scooter because it is not a medical or physical necessity to remain in current living situation. He also has good support from family for the IADL shopping and has meals provided from RVT assisted living. Participant has a diagnoses of cognitive impairment, and demonstrated decreased safety awareness and impulsivity when transferring on/off scooter. Participant also utilizes the substance of marijuana daily posing a safety risk to himself, motor vehicles, and pedestrians. If power scooter were to be issued, participant is at risk for muscle atrophy, decreased endurance, decreased balance, and increased staff and family dependency for basic ADL care. (Exhibit A, p 4; Testimony)

5. On February 24, 2023, PACE sent Petitioner a written notice informing Petitioner that his request for a power scooter was denied. (Exhibit B; Testimony)
6. On February 24, 2023, PACE received Petitioner's request for an internal appeal. (Exhibit C; Testimony)
7. On March 14, 2023, after a review by an independent internal appeals committee, PACE notified Petitioner in writing that the committee was upholding the decision of the IDT to deny Petitioner a power scooter. (Exhibits D, E; Testimony)
8. On March 29, 2023, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's request for hearing. (Exhibit F).

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.

PACE services are available as part of the Medicaid program:

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

3.13 APPLICANT APPEALS

3.13.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 on the MOAHR 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.

*Medicaid Provider Manual
Program of All-Inclusive Care for the Elderly Chapter
January 1, 2023, pp 1-2, 7*

With regard to medical necessity, the Medicaid Provider Manual indicates:

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:
 - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
 - that are experimental or investigational in nature; or
 - for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

*Medicaid Provider Manual
Mental Health/Substance Abuse Chapter
January 1, 2023, pp 13-14*

With regard to scooters and power scooters, the Medicaid Provider Manual provides:

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 1W, 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 Chapter
January 1, 2023, p 110*

PACE's Director of Quality and Compliance (DQC) testified that the IDT reviewed Petitioner's request for a power scooter and decided not to approve it for several reasons. PACE's DQC noted that there was concern whether Petitioner could use the scooter safely due to his balance, impulsivity, and marijuana use. PACE's DQC also testified that power scooters are meant to help with independence in the home and for short distances, and here, Petitioner is independent with mobility in his home and for short distances. PACE's DQC also noted that Petitioner's internal appeal went through an independent review committee consisting of persons outside the PACE organization, who upheld the denial.

Petitioner testified that the day the OT came to do the assessment, she was distracted by another resident at his assisted living facility, who kept interfering with the assessment. Petitioner indicated that the resident kept complaining that he could not understand how Petitioner was getting a power scooter before him. Petitioner testified that he is very responsible but hardly got to ride the scooter during the assessment.

Petitioner's daughter testified that she is Petitioner's representative, and she was not aware of the assessment. Petitioner's daughter indicated that everything is supposed to be mailed to her. Petitioner's daughter testified that Petitioner has an amputated leg and sometimes the prosthetic leg he has gives him difficulty if he wears it too long. Petitioner's daughter indicated that a power scooter would help him get around when this occurred.

In response, PACE's DQC indicated that she did not see that Petitioner had a guardianship or power of attorney on file with PACE.

Petitioner's daughter testified that she was told she did not need a legal document to control her father's affairs because she is his only child. Petitioner's daughter also indicated that when Petitioner signed up for PACE, PACE was told that everything needed to go through her.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying his request for a power scooter. Based on the above evidence presented, this Administrative Law Judge finds that Petitioner has failed to meet this burden of proof.

As PACE's DQC pointed out, and the above policy supports, power scooters are approved only if they will help with ADLs in the home. Here, Petitioner is already independent with his ADLs in the home but wanted the power scooter to go to the store and visit friends in the neighborhood. While it is understandable that Petitioner would like more independence, such use of a power scooter is not supported by policy. Furthermore, PACE indicated that it would provide Petitioner a manual wheelchair to assist him if he wanted to go further distances outside his home. In addition, while Petitioner may have felt like the OT was distracted during the assessment, the assessment report she completed was very complete and detailed. Finally, while PACE should include Petitioner's daughter in assessments if that is Petitioner's choice, her presence here would not have made a difference given that Petitioner's desired use of the power scooter is simply not supported by policy.

Accordingly, this Administrative Law Judge finds that Petitioner has failed to prove, by a preponderance of the evidence, that Respondent's denial was improper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that Respondent properly denied Petitioner's request for a power scooter.

IT IS THEREFORE ORDERED that:

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