

## **ISSUE**

Did Department properly deny Petitioner's request for physical therapy?

## **FINDINGS OF FACT**

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

1. Department 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. On or around October 2, 2023, Petitioner made a request for Physical Therapy. (Exhibit A.)

3. On or around October 11, 2023, an Interdisciplinary Team, discussed Petitioner's request for physical therapy and agreed with a recommendation to deny the request as Petitioner's goals and preferences do not align with the plan of care. (Exhibit A.)
4. At some point in time, Petitioner requested a second opinion assessment by a new physical therapist as a result of being disappointed with her current physical therapy plan of care. (Exhibit A.)
5. A second assessment was conducted at Petitioner's request, and it was noted Petitioner was seen ambulating independently throughout areas of her home and without the use of her rollator walker. At the time of the assessment, Petitioner declined a physical evaluation due to pain and past trauma. Petitioner indicated she doesn't want to do exercises and would like things done to her instead and further indicated a wish to continue using her vibration plate in her home independently. (Exhibit A.)
6. On October 13, 2023, Department sent Petitioner an Advance Action Notice. The notice indicated Petitioner's request for Physical Therapy was being denied effective October 13, 2023. (Exhibit A.) The notice stated specifically:

REDACTED's goals and preferences do not align with the physical therapist's plan of care, PPT declined physical evaluation during assessment due to pain and past trauma. PPT was able to use her vibration plate with success and was willing to continue to use.'
7. On October 27, 2023, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing. (Exhibit A.)

### 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 eligibility for it, the Medicaid Provider Manual (MPM) provides:

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<sup>1</sup> Exhibit A, p 2.

## **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 federal 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 ...<sup>2</sup>

Here, Department denied Petitioner's request for physical therapy.

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

<sup>2</sup> Medicaid Provider Manual, PACE, October 1, 2022, pp 1-2.

Given the available information and applicable policies in this case, Petitioner has not met their burden of proof, and the Department's decision must, therefore, be affirmed.

Department's witnesses credibly testified that Petitioner's assessment and Petitioner's records demonstrate that while Petitioner previously received physical therapy, Petitioner's goals and preferences do not align with the recommendations from the physical therapist. Furthermore, Petitioner declined a physical evaluation during the assessment due to pain and past trauma and could not be fully evaluated. Accordingly, given the record in this matter, the Department's decision was proper.

#### **DECISION AND ORDER**

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Department properly denied Petitioner's request for physical therapy.

**IT IS THEREFORE ORDERED** that:

Department's decision is **AFFIRMED**.