

ISSUE

Did Respondent properly deny Petitioner's request for a lighter 4-wheel walker 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 REDACTED who has been receiving services through PACE. (Exhibit A; Testimony.)
3. On or about July 26, 2024, PACE received a request from Petitioner for a lighter 4-wheel walker. (Exhibit A, p 6; Testimony.)
4. On June 6, 2024, PACE's physical therapist (PT) had completed an assessment for a lighter 4-wheel walker. Following the assessment, PACE's PT concluded that Petitioner did not need a lighter 4-wheel walker. (Exhibit A, p 7; Testimony.)

Specifically, PACE's OT concluded, in relevant part:

REDACTED needs moderate physical assist to get his current 4ww or a lighter alternative 4ww in and out of the car. (*Id.*)

5. On July 26, 2024, PACE's Interdisciplinary Team met to review Petitioner's request for a lighter 4-wheel walker and concluded, in relevant part:

The 12.5 lb walker did not significantly improve his ability or safety when we practiced car transfers on June 6th, and that the smaller wheels are less efficient than the wheels on his current walker, and that PT is recommending he have assistance with car transfers and community mobility. (Exhibit A, pp 4-5; Testimony.)

6. On July 26, 2024, PACE sent Petitioner an Adequate Action Notice Denial of Service informing Petitioner that the request for a lighter 4-wheel walker was denied. (Exhibit A, pp 14-20; Testimony.) Specifically, the Notice indicated in relevant part:

The reason for this action is this walker does not improve your function with car transfers compared to your current four-wheeled walker. (Exhibit A, p 14.)

7. On August 12, 2024, PACE received Petitioner's request for an internal appeal. (Exhibit A, p 21; Testimony.)
8. On August 27, 2024, after a review by an independent appeals committee, PACE notified Petitioner in writing that the committee was upholding the decision of the IDT to deny Petitioner a lighter 4-wheel walker. (Exhibit A, p 22-30; Testimony.)
9. On October 21, 2024, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's request for hearing. (Exhibit 1.)

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
April 1, 2024, 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
April 1, 2023, pp 13-14*

With regard to lighter 4-wheel walkers, the Medicaid Provider Manual provides:

2.45 WALKERS

Definition

Walkers include, but are not limited to, rigid, wheeled, heavy duty, and folding.

Standards of Coverage

Walkers may be covered when the beneficiary has impaired ambulation and requires a walker for safe and independent ambulation.

Documentation

Documentation must be less than six months old and include:

- Diagnosis/medical condition related to the need for the service.

- Functional level possible with use of walker.
- Medical reason for type of attachment or modification, if applicable.
- Medical reason for heavy-duty walker (e.g., obesity, severe neurological disorder, or restricted use of hands).
- Duration of need and frequency of use.
- Identification of other specific economic alternatives ruled out.
- Identification of make, model, serial number, and warranty information.
- Statement of medical need for the specific walker requested.

In addition, for each walker type, the following must be included:

■ **Standard Walkers**

- Medical/functional reason a cane would not meet the beneficiary's ability to perform MRADL

■ **Walker with Trunk Support**

- Medical/functional reason a standard walker would not meet the beneficiary's ability to perform MRADL

■ **Enclosed Walker with Posterior Seat**

- Medical/functional reason a standard walker would not meet the beneficiary's ability to perform MRADL

■ **Heavy-Duty Walker**

- Medical/functional reason for a heavy-duty walker (e.g., obesity, severe neurological disorder, restricted use of hands)

PA Requirements

PA is not required for walkers if the Standards of Coverage and Documentation are met.

PA is required for:

- Replacement within five years.
- Additional attachments (e.g., arm troughs).

- Replacement within five years for age 21 and over.
- Replacement within two years for under age 21.

Payment Rules

Walkers may be a capped rental or purchase item. After the first ten months of rental, necessary repairs and/or replacements of accessories are separately reimbursable.

*Medicaid Provider Manual
Medical Supplier Chapter April
1, 2024, p 109 Emphasis
added*

PACE's Quality and Compliance Analyst (QCA) testified that the IDT reviewed Petitioner's request for a lighter 4-wheel walker and decided not to approve it because Petitioner needed the same level of assistance getting the lighter 4-wheel walker in the car as he did with his current walker.

Petitioner testified that he thinks his care is too expensive for PACE. Petitioner indicated that he was taking a medication "Vyndamax," that cost \$22,000 per month, but PACE discontinued the medication claiming it was not helping with Petitioner's neuropathy. Petitioner testified that he was not taking the medication solely for help with neuropathy. Petitioner mentioned that PACE had also denied Petitioner's request in the past for a ROHO seat cushion. Petitioner testified that he was tired on the day he tried the two different walkers because he had to walk across the parking lot first and had just eaten lunch. Petitioner also mentioned that PACE had denied him a medication for pain when he came down with a UTI. Petitioner testified that while he can get his current walker out of his vehicle, he has difficulty getting it back in. Petitioner indicated that he thinks his current walker really weighs closer to 22 pounds. Petitioner testified that PACE says they provide "all-inclusive care," but he does not think that is right.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying the request for a lighter 4-wheel walker. Based on the above evidence presented, this Administrative Law Judge finds that Petitioner has failed to meet this burden of proof.

According to the above policy, in order to get a specific walker, such as the lighter 4-wheel walker requested here, there must be a "Statement of medical need for the specific walker requested." (MPM, §2.45; Emphasis added.) In addition, PACE may deny requests "for which there exists appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services." (MPM, §2.5.D.) Here, Petitioner is requesting the lighter 4-wheel walker (12.5 lb.) because he believes it will be easier for him to load into his car than his current walker (16 lb.). However, according to a PT assessment, Petitioner needs as much assistance loading the lighter walker into the car as he does with his current walker. As such, there is no "medical need" for the specific walker requested, and there

is another "appropriate" and "cost-effective" device that can meet Petitioner's needs, namely his current walker.

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 lighter 4-wheel walker.

IT IS THEREFORE ORDERED that:

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