[redacted]
[redacted], MI [redacted]

Date Mailed: January 10, 2022
MOAHR Docket No.: 21-005396
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on January 4, 2022. [redacted], Petitioner's brother, appeared and testified on Petitioner's behalf. Petitioner; [redacted], Petitioner's nephew; and [redacted], Petitioner's daughter; also testified as witnesses for Petitioner. Laura Rynberg, Quality Improvement Specialist, appeared and testified on behalf of PACE of Southwest Michigan, a Program of All-Inclusive Care for the Elderly (PACE) organization. [redacted], Physical Therapist, and [redacted], Occupational Therapist, also testified as witnesses for Respondent.

During the hearing, Petitioner's Request for Hearing was admitted into the record as Exhibit #1, page 1. Respondent also submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-35.

ISSUE

Did Respondent properly deny Petitioner's request for external 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. 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 is a Medicaid beneficiary who has been enrolled in PACE and receiving services through Respondent. (Exhibit A, pages 5-8).

3. Beginning in February of 2017, Petitioner has received physical therapy through Respondent. (Exhibit A, pages 5-13).

4. However, she has made no real progress and there has been no significant change in her functional status or abilities over the years. (Exhibit A, pages 6, 12; Testimony of Petitioner's representative; Testimony of Petitioner; Testimony of Petitioner's Nephew; Testimony of Petitioner's Daughter; Testimony of Physical Therapist).

5. During the period of July 9, 2019, to September 30, 2019, Petitioner also received physical therapy at a provider external to Respondent, Lakeland Rehabilitation Services (Lakeland). (Exhibit A, pages 6, 18-23).

6. However, Petitioner was ultimately discharged from Lakeland due to a lack of progress. (Exhibit A, page 6).

7. On or about June 29, 2021, Petitioner requested physical therapy through another new external provider, Mary Free Bed. (Exhibit A, page 5).

8. On July 2, 2021, Respondent sent Petitioner written notice that her request for external physical therapy had been denied. (Exhibit A, page 3).

9. With respect to the reason for the denial, the notice stated that:

> Your Interdisciplinary team has decided that the referral to Mary Free Bed for Physical Therapy is not appropriate for your plan of care. This is due to a history of poor compliance with therapy depts at PACE and Lakeland. Our team does not believe increased therapy efforts would improve functional ability at this time.
>
> *Exhibit A, page 3*

10. Petitioner subsequently filed an Internal Appeal with Respondent regarding the denial of her request for external physical therapy. (Exhibit A, page 4).

11. Respondent's Internal Appeals Committee then reviewed Petitioner's case, and it determined that the denial should be upheld on the basis that, given Petitioner's medical conditions and previous services, increased therapy would not be beneficial. (Exhibit A, pages 34-38).

12. On November 9, 2021, the Michigan Office Administrative Hearings and Rules (MOAHR) received the Request for Hearing filed by Petitioner in this matter. (Exhibit #1, page 1).

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, July 1, 2021 version
PACE Chapter, pages 1-2
(italics added for emphasis)

As provided in that policy, Respondent is to be the sole source of services for Medicare and Medicaid beneficiaries who choose to enroll with it and its service package must include all Medicaid covered services, in addition to other services determined necessary by the interdisciplinary team for the individual beneficiary.

With respect to the Medicaid covered service of physical therapy, the MPM states in part:

4.2 PHYSICAL THERAPY

MDHHS uses the terms Physical Therapy, PT, and therapy interchangeably. PT is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses for physical therapy services when provided by any of the following:

- A licensed physical therapist.

- A licensed physical therapy assistant under the supervision of a physical therapist (i.e., the physical therapy assistant services must follow the evaluation and treatment plan developed by the physical therapist, and the physical therapist must supervise and monitor the physical therapy assistant's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and co-signed by the supervising physical therapist.

- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) a physical therapist. All documentation must be reviewed and co-signed by the supervising physical therapist.

PT is considered an all-inclusive charge. Medicaid does not reimburse for a clinic room charge in addition to therapy services unless the room charges are unrelated. MDHHS expects physical therapists and physical therapy assistants to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association. *PT must be medically necessary, reasonable and required to achieve one or more of the following:*

- *Return the beneficiary to the functional level prior to illness or disability;*

- *Return the beneficiary to a functional level that is appropriate to a stable medical status;*

- *Prevent a reduction in medical or functional status had the therapy not been provided.*

Therapies provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital.

* * *

> *PT is expected to result in measurable improvement that is significant to the beneficiary's ability to perform mobility skills appropriate to his/her chronological, developmental, or functional status. Functional improvements must be achieved in a reasonable, and generally predictable, amount of time as specified in the short- and long-term goals identified on the evaluation/re-evaluation and treatment plan. Functional improvements must be maintainable. Medicaid does not cover therapy if the beneficiary's maximum functional potential has been realized, the beneficiary has plateaued, or the therapy has no impact on the beneficiary's ability to perform age-appropriate tasks.* However, medically necessary habilitative therapy services may be covered under EPSDT or Healthy Michigan Plan.
>
> Medicaid only covers PT services that require the skills, knowledge, and education of a physical therapist. Medicaid does not cover interventions provided by another practitioner or caregiver (e.g., registered nurse, licensed occupational therapist, family member, teacher, etc.).
>
> *MPM, July 1, 2021 version*
> *Therapy Services Chapter, pages 18-19*
> *(italics added for emphasis)*

Here, Petitioner has been approved for PACE services at all times relevant to this matter and it is only the denial of a particular service in dispute, with Petitioner requesting external physical therapy and Respondent denying the request on the basis that external physical therapy is not appropriate for Petitioner's plan of care.

In appealing that 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 it had at the time it made the decision.

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet that burden of proof and that Respondent's decision must therefore be affirmed.

Petitioner has been receiving physical therapy since February of 2017, through either Respondent or an external provider, and it is undisputed that she has made no real progress and that there has been no significant change in her functional status or abilities over the years. Moreover, Petitioner's representative and witnesses also agreed that there is nothing different about the requested physical therapy at a new external

provider, and they instead argue that Respondent has done all it can and that it is best for someone else to try.

However, that hope that physical therapy at another provider might go differently does not satisfy the applicable criteria. As discussed above, to be covered, physical therapy must be expected to result in significant, measurable improvement and Medicaid does not cover therapy if a beneficiary's maximum functional potential has been realized, she has plateaued, or the therapy will have no impact on her ability to perform age-appropriate tasks. Here, given Petitioner's undisputed lack of improvement despite years of physical therapy provided at different locations, there is no basis for expecting that the same services at a new external provider would result in improvement, and, as such, Respondent properly denied the request.

DECISION AND ORDER

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

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED**.

Steven Kibit

SK/tem

Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

Roxanne Perry
400 S Pine St
Capital Commons
Lansing, MI 48909

Petitioner

[redacted], MI [redacted]

Community Health Rep

PACE OF SOUTHWEST MICHIGAN
c/o Laura Rynberg
2900 Lakeview Avenue
Saint Joseph, MI 49085

Authorized Hearing Rep.

[redacted], MI [redacted]