[redacted]
MI [redacted]

Date Mailed: May 18, 2022
MOAHR Docket No.: 22-001329
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 Petitioner's request for a hearing.

After due notice, a telephone hearing was held on April 28, 2022. Petitioner appeared and testified on her own behalf. [redacted], a staff member at the home where Petitioner lives, also testified as a witness for Petitioner. Michelle Reardon, Quality Assurance Director, appeared and testified on behalf of the Respondent, PACE North, a Program of All-Inclusive Care for the Elderly (PACE) organization.

During the hearing, Petitioner's request for hearing was admitted into the record as Exhibit #1, pages 1-2. Respondent also submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-29.

ISSUE

Did Respondent 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. 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 [redacted] ([redacted]) year-old Medicaid beneficiary who has been enrolled in PACE and receiving services through Respondent. (Exhibit A, page 10).

3. On September 17, 2021, Respondent assessed Petitioner for PT. (Exhibit

A, pages 7-9).

4. During that assessment, Respondent described Petitioner's medical history as including atherosclerosis of aorta; chronic kidney disease due to diabetes mellitus; chronic obstructive pulmonary disease; a cerebrovascular accident; diabetes; dysarthria; hemiplegia; hyperlipidemia; major depression; and obesity. (Exhibit A, page 7).

5. It also noted that Petitioner was currently non-ambulatory, but that she could use a wheelchair independently and had both a four-wheel and a two-wheel walker available for her. (Exhibit A, page 7).

6. It further noted that Petitioner had poor balance and was at a high risk for falls. (Exhibit A, pages 8-9).

7. Following the assessment, Petitioner was approved for PT to address her deficits and facilitate increased safety within community living. (Exhibit A, page 9).

8. Petitioner then received PT until January 14, 2022. (Exhibit A, page 2).

9. Petitioner's functional levels did not improve while receiving PT and she was discharged on January 14, 2022. (Exhibit A, page 2; Testimony of Petitioner).

10. However, Petitioner subsequently requested additional PT to address her walking deficits. (Exhibit A, page 4).

11. On February 24, 2022, Respondent sent Petitioner an Adequate Action Notice stating that her request for physical therapy had been denied. (Exhibit A, pages 13-19).

12. With respect to the reason for the action, the notice stated in part:

> The reason for this action is that our physical therapist treated you with 14-weeks of PT within the last six months, but this didn't increase your ability to walk independently. Further skilled PT is unlikely to improve your ability to walk due to your disease prognosis and your medical history.
>
> *Exhibit A, page 13*

13. On March 2, 2022, Petitioner filed an Internal Appeal with Respondent regarding the decision to deny PT. (Exhibit A, page 20).

14. In that appeal, Petitioner stated that she feels she needs more PT to reach

her goals. (Exhibit A, page 20).

15. On March 12, 2022, Respondent sent Petitioner written notice that her Internal Appeal was denied. (Exhibit A, pages 22-26).

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

> The denial of your request for skilled physical therapy was upheld because you have reached your functional baseline and further gains are not likely to disease prognosis.
>
> *Exhibit A page 22*

17. On March 29, 2022, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed by Petitioner in this matter regarding Respondent's decision. (Exhibit #1, pages 1-2).

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:

> **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 . . .

MPM, January 1, 2022 version
PACE Chapter, pages 1-2
(italics added for emphasis)

Here, Respondent denied Petitioner's request for PT pursuant to the above policy and on the basis that Petitioner had reached her functional baseline and additional PT was unlikely to improve her ability to walk given her medical diagnoses and history.

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 the decision in light of the information that was available at the time the decision was made.

Given the available information and applicable policies in this case, Petitioner has failed to meet that burden of proof and Respondent's decision must therefore be affirmed.

Petitioner was previously approved for PT, but it is undisputed that Petitioner did not have any functional improvement while receiving those services and, while Petitioner wanted to keep trying, Respondent's interdisciplinary team credibly found further services were not medically necessary as Petitioner had reached her functional baseline and was unlikely to improve with more PT.

Moreover, the interdisciplinary team's findings are consistent with Medicaid coverage policies regarding PT, which provide in part that:

> 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.
>
> *MPM, January 1, 2022 version*
> *Therapy Services Chapter, page 18*

Additionally, while Petitioner testified that she has improved since stopping physical therapy and that it would now be beneficial, that new information was not provided to Respondent at the time of the request in this case, as it had not yet occurred, and the undersigned Administrative Law Judge is limited to reviewing Respondent's decision in light of the information that was available at the time the decision was made.

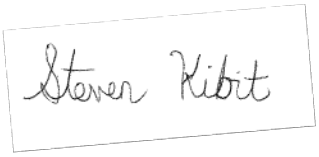
To the extent Petitioner has additional or updated information to provide, she can always submit a new authorization request with that additional or updated information. With respect to the issue in this case however, Respondent's decision must be affirmed given the available information and applicable policy.

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 physical therapy.

IT IS, THEREFORE, ORDERED that:

Respondent's decision is **AFFIRMED**.



SK/dh

Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioner 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 Capitol Commons Lansing, MI 48909
Petitioner	[redacted] MI [redacted]
Community Health Rep	PACE North Attn: Michelle Reardon 2325 Garfield Rd. N Traverese City, MI 49686