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Date Mailed: August 11, 2022
MOAHR Docket No.: 22-002942
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a hearing was held on August 10, 2022. Petitioner appeared and testified on his own behalf. Elaine Catlin, Social Worker, Senior Care Partners PACE, assisted Petitioner in his home for the hearing.

Mandy Bozell, Compliance and Privacy Specialist, appeared and testified on behalf of Respondent, Senior Care Partners PACE. (PACE or Respondent). Malory Smith, Community Supports Department Lead and Hannah Butlat, Physical Therapist, appeared as witnesses for Respondent.

ISSUE

Did Respondent properly deny Petitioner's request for repair of his personal motorized 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. Senior Care Partners 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 a male Medicaid beneficiary receiving services through Respondent PACE. (Exhibit A; Testimony).

3. On or about April 26, 2022, PACE received a request from Petitioner to repair his personal motorized scooter. Petitioner reported that the right

arm rest was broken, and the joystick was not working. (Exhibit A, p 32; Testimony).

4. On April 28, 2022, PACE's physical therapist (PT) met with Petitioner in the day center to discuss the request for power scooter repairs. After an assessment, PACE's PT determined that Petitioner has a manual wheelchair that he can use to complete his ADL's and he can propel himself up to 500 feet both indoors and outdoors with the manual wheelchair. PACE's PT also determined that Petitioner has a 4-wheel walker which he can use to ambulate distances of up to 15 feet. Based on these findings, PACE's PT recommended to PACE's Interdisciplinary Team (IDT) that Petitioner's request for repairs to his personal power scooter be denied. (Exhibit A, p 34; Testimony).

5. On April 29, 2022, the IDT reviewed Petitioner's request and agreed with PACE's PT that Petitioner's request should be denied. Following this review, PACE sent Petitioner an Advance Action Notice, informing Petitioner that his request for repair of his personal motorized scooter was denied. The notice indicated, "Team denied Service Determination Request due to Peter being independent at wheelchair level to complete ADL's, and is independent with mobility with a manual wheelchair and is able to ambulate short distances with 4WW." (Exhibit A, pp 2-9; Testimony).

6. On July 18, 2022, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's request for hearing. (Exhibit A, p 31).

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

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3.13 APPLICANT APPEALS

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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, 2022, 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, 2022, pp 13-14*

PACE's PT testified that she met with Petitioner in the day center to discuss the request for power scooter repairs and, after an assessment, determined that Petitioner has a manual wheelchair at home that he can use to complete his ADL's and he can propel himself up to 500 feet both indoors and outdoors with the manual wheelchair. PACE's PT testified that she also determined that Petitioner has a 4-wheel walker which he can use to ambulate distances of up to 15 feet. Based on these findings, PACE's PT testified that she recommended to PACE's IDT that Petitioner's request for repairs to his personal power scooter be denied.

PACE's Community Supports Department Lead (CSDL) testified that she served on the IDT that reviewed the PT's recommendation and the team also determined that Petitioner's request should be denied because Petitioner was independent with his manual wheelchair and 4-wheel walker at home and in the community. PACE's CSDL also noted that PACE does not provide for power wheelchairs or scooters in the community because they contract with other services to arrange for participants' transportation.

Petitioner testified that while he does have a manual wheelchair, he asked PACE for a power wheelchair before he got the manual wheelchair and they denied him. Petitioner indicated that he purchased the power scooter on his own and now it needs repair. Petitioner indicated that he cannot walk at all as his right side is just not there following his stroke. Petitioner testified that he needs a power wheelchair to get around the home and that is all he uses at home. Petitioner also noted that he has used his power wheelchair in the community and the companies PACE contracts with for transportation have transported him with his power wheelchair.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying his request for repair of his personal motorized scooter. Based on the above testimony and evidence, this Administrative Law Judge finds that Petitioner has not met this burden of proof. The evidence clearly shows that Petitioner is independent both at home and in the community with his manual wheelchair. Petitioner can perform all of his ADL's from the manual wheelchair and he can propel the manual wheelchair up to 500 feet both indoors and outdoors. Petitioner also has a 4 wheel walker that he can use to ambulate up to 15 feet. In making this determination, PACE relied on personal observations of staff at the PACE day center who have observed Petitioner using his manual wheelchair as indicated and Petitioner does not deny these facts. Given this, it cannot be said that a repair of Petitioner's personal motorized scooter is medically necessary.

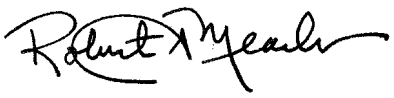
Accordingly, this Administrative Law Judge finds that Petitioner has failed to prove, by a preponderance of the evidence, that Respondent improperly denied Petitioner's request for repair of his personal motorized scooter.

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 repair of his personal motorized scooter.

IT IS THEREFORE ORDERED that:

The Respondent's decision is AFFIRMED.



RM/dh

Robert J. Meade
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

Via Electronic Mail:

Community Health Rep.
Senior Care Partners PACE
200 W. Michigan Ave., #104
Battle Creek, MI 49017
A.Bozell@seniorcarepartnersmi.org

DHHS Department Contact
Roxanne Perry
Capitol Commons
400 S. Pine St.
Lansing, MI 48909
MDHHS-MSA-PACE@michigan.gov

Via First Class Mail:

Petitioner
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