

ISSUE

Did Department properly deny Petitioner's request for a power mobility device?

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) and oversees PACE in Petitioner's geographical area.
2. Petitioner has been enrolled in PACE and receiving services through Department. (Exhibit A; Testimony).
3. On or around October 10, 2024, Petitioner made a request to the Department seeking a power mobility device due to shortness of breath. (Exhibit A; Testimony.)
4. On October 10, 2024, the Department performed an assessment of Petitioner. During the assessment, Petitioner presented with a four wheeled walker and was observed to walk from the bus to the therapy gym (approximately 140 feet). Petitioner had an oxygen saturation level of 95% and reported that she has an albuterol inhaler which was helping. (Exhibit A; Testimony.)
5. Following the assessment, the clinician performing the assessment did not recommend a power mobility device as the Petitioner could walk safely with the four-wheel walker; and shortness of breath concerns could be resolved with more frequent breaks and using the albuterol inhaler. (Exhibit A.)
6. On October 11, 2024, the Department sent Petitioner an Adequate Action Notice Denial of Service, denying Petitioner's request for a power mobility device. (Exhibit A.)
7. On October 11, 2024, the Petitioner requested an internal review. (Exhibit A.)
8. On November 1, 2024, the Department sent Petitioner an appeal review letter indicating the initial denial was upheld as the committee agreed that Petitioner could walk independently using a four-wheeled walker; had no recent falls; and was currently using oxygen to manage shortness of breath. (Exhibit A.)
9. On January 22, 2025, 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:

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
- 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 care¹

Here, Petitioner has been approved for PACE services at all times relevant to this matter; and it is only the denial of her request for a power mobility device that is in dispute.

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 Department's decision in light of the information available at the time the decision was made.

Given the record and available information in this case, Petitioner has failed to meet her burden of proof; and Department's decision must, therefore, be affirmed.

It is undisputed in this case that Petitioner currently uses a four-wheel walker, and that she is able to do so independently but with shortness of breath and pain in her legs.

However, while Petitioner currently has some shortness of breath issues and pain in her legs, it is clear that a power mobility device is not medically necessary given her current level of functioning and the interventions that are available.

Accordingly, given Petitioner's current functioning and the lack of medical necessity for a power mobility device, Department properly denied Petitioner's request for a power mobility device.

To the extent Petitioner's circumstances change or she has additional information to provide, then she can always request a power mobility device again in the future. With respect to the issue in this case; however, Department's decision is affirmed.

DECISION AND ORDER

¹ MPM, PACE, April 1, 2024, pp 1-2.

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

IT IS, THEREFORE, ORDERED that:

Department's decision is **AFFIRMED**.