ISSUE

Did Respondent properly deny Petitioner's request for an external hip x-ray 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 female who has been receiving services through PACE. (Exhibit A; Testimony.)

3. In REDACTED 2025, Petitioner reported worsening right hip pain and requested an x-ray. (Exhibit A, p 33, 41; Testimony.)

4. On REDACTED 2025, PACE's Primary Care Provider (PCP) evaluated Petitioner and noted that Petitioner had a recent right hip x-ray that showed arthritis. (Exhibit A, p 99; Testimony.) The PCP noted concern that Petitioner would not participate fully in manual therapy to help release muscle knots and tension which would improve her pain significantly. (Exhibit A, pp 33, 40; Testimony.) Petitioner's PCP informed Petitioner that therapy might hurt at the beginning but would improve over time and she would feel less pain. *(Id.)*

5. On April 18, 2025, PACE's Interdisciplinary Team (IDT) reviewed and denied Petitioner's request for an external hip x-ray, citing the assessment completed by the PCP and a Denial of Service, Adequate Action Notice was issued to Petitioner that same day. (Exhibit A, pp 2-9; Testimony.)

6. On April 23, 2025, Occupational Therapy (OT) staff assessed Petitioner, and noted that while Petitioner complains of hip pain, it minimally impacts her daily routine. OT noted that Petitioner is seen dancing in the day center, participating in activities, and continues to climb the stairs daily with independence as her bedroom is upstairs. (Exhibit A, p 33; .)
7. On April 24, 2025, Physical Therapy (PT) also evaluated Petitioner, noting that Petitioner can ambulate in the community for long distances without the use of any assistive device. (Exhibit A, p 34; Testimony.) PT noted that Petitioner was independent with bed mobility and transfers from all surfaces. *(Id.)* PT also noted that Petitioner's pain does not limit her activities or mobility. *(Id.)*

8. On July 8, 2025, 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

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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, 2025, 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, 2025, pp 13-14

PACE's witnesses testified that Petitioner's request for an x-ray was denied following assessments by her PCP, OT, PT and a review by the IDT, all of which found the request not medically necessary.

Petitioner testified that her hip is constantly hurting 24/7. Petitioner indicated that she has only been walking outside a few times this summer due to her pain. Petitioner testified that she would like an x-ray so that she can figure out what is causing this pain. Petitioner indicated that she has had pain for more than one year, but it has worsened this year. Petitioner testified that she has fallen, with the last fall being towards the end of July. Petitioner admitted that she does not use any assistive devices and is able to climb stairs on her own.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying the request for an x-ray. 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, PACE may deny requests "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." (MPM, §2.5.D.) Here, Petitioner is requesting an x-ray because she believes that it will show what is wrong with her hip. However, given that Petitioner had a recent hip x-ray in REDACTED 2024 that showed arthritis, it is more likely than not that it is

the arthritis that has worsened and is causing her more pain. Petitioner can participate in therapy to try to improve the pain. If Petitioner completes therapy without relief, she can request another x-ray at that time. However, at this time it is clear that Petitioner's pain can be treated with less restrictive and cost-effective services, including PT and OT, so an x-ray would not be medically necessary at this time.

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 an x-ray.

IT IS THEREFORE ORDERED that:

The Respondent's decision is AFFIRMED.