Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: November 24, 2025
Docket No.: 25-033646
Case No.: [redacted]
Petitioner: [redacted]

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MI [redacted]

This is an important legal document. Please have someone translate the document.

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এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

Este es un documento legal importante. Por favor, que alguien traduzca el documento.

这是一份重要的法律文件。请让别人翻译文件。

Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

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Case No.: [redacted]
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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 video hearing was held on November 19, 2025. [redacted], [redacted], Petitioner appeared and testified on her own behalf. Quianna Harrison, CEO, Senior Care Partners PACE, and Molly Seene, RN, Senior Care Partners PACE, appeared to assist Petitioner. [redacted], Home Care Provider and [redacted], Family Friend, appeared as witnesses for Petitioner.

Alyssa Brandt, Quality Improvement Specialist, appeared and testified on behalf of Respondent, Senior Care Partners PACE. (PACE or Respondent). Dr. Nicholas Smith, Primary Care Physician; [redacted], Center Manager; [redacted], Manager, Therapy; and [redacted], Social Worker, appeared as witnesses for Respondent.

ISSUE

Did Respondent properly deny Petitioner's request for a power mobility device 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 [redacted] who has been receiving services through PACE. (Exhibit A; Testimony).

3. PACE received a request from Petitioner for a power mobility device due to progressive mobility limitations, chronic pain, fatigue, and instability stemming from a failed spinal fusion surgery and subsequent spinal, muscular, and neurological impairments. Petitioner asserts that walking, even short distances, causes leg fatigue, imbalance, stumbling, and falls, and that a scooter would preserve energy, support participation in community life, improve mental health, and provide stability she describes as "scooter-legs.". (Exhibit A, pp 28, 33-35; Testimony)

4. In late 2023, prior to joining PACE, Petitioner was approved for a power mobility scooter through her private insurance. (Exhibit A, pp 47-48; Testimony.) The scooter was too big and had to be returned. (Testimony.)

5. Respondent conducted assessments through the participant's primary care provider (PCP), physical therapy (PT), occupational therapy (OT), and social work (MSW). These assessments documented that:

   - Petitioner's pain is adequately controlled.
   - She needs to rest after 5–7 minutes of walking with a walker due to fatigue, but no decline due to medication side-effects is suspected.
   - Petitioner ambulated approximately 30 feet twice with a walker, could open exit doors without the walker, and displayed normal step length and width, with no observed loss of balance.
   - She was observed walking inside her home at times without any assistive device.
   - She remained independent in transfers, bed mobility, and most activities of daily living (ADLs).
   - She demonstrated ability to bend repeatedly to pick up objects without loss of balance, though with mild fatigue.
   - Counseling and spiritual care were already addressing mental health concerns.

   (Exhibit A; pp 76-82; Testimony.)

6. On June 27, 2025, PACE sent Petitioner an Adequate Action Notice Denial of Service informing Petitioner that the request for a power mobility device was denied. (Exhibit A, pp 3-11; Testimony)

7. On [redacted] 2025, Dr. Adrienne Solis-Sherman, Director of Program Integrity, conducted an in-home visit with Petitioner to review her request for a power mobility device as part of Petitioner's internal appeal. (Exhibit A, pp 39-45; Testimony.)

8. On August 14, 2025, after a review by an independent appeals committee, PACE notified Petitioner in writing that the committee was upholding the decision of the IDT to deny Petitioner a power mobility device. (Exhibit A, pp 29, 84-85, 126; Testimony)

9. On [redacted], 2025, Petitioner was seen in the emergency department of Beacon Hospital where Dr. Nathan Whelman, MD, penned a letter indicating that Petitioner would benefit from a mobility scooter. (Exhibit A, pp 46, 132-133; Testimony.)

10. On September 23, 2025, the Michigan Office of Administrative Hearings and Rules (MOAHR) received Petitioner's request for hearing. (Exhibit A, pp 12-20).

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

With regard to power mobility devices, the Medicaid Provider Manual provides:

Power Wheelchair or Power-Operated Vehicle (POV) in Both Community Residential and Institutional Residential Settings

May be covered if the beneficiary meets **all** of the following:

- Lacks ability to propel a manual wheelchair, or has a medical condition that would be compromised by propelling a manual wheelchair, for at least 60 feet over hard, smooth, or carpeted surfaces with or without rest intervals.
- Requires use of a wheelchair for at least four hours throughout the day.
- Is able to safely operate, control and maneuver the wheelchair in their environmental setting, including through doorways and over thresholds up to 1½", as appropriate.
- Has a cognitive, functional level that permits safe operation of a power mobility device with or without training.
- Has visual acuity that permits safe operation of a power mobility device.
- For a three-wheeled power mobility device, has sufficient trunk control and balance.

Medicaid Provider Manual
Medical Supplier Chapter
April 1, 2025, p 110

Respondent determined that Petitioner's current assistive devices, including a four-wheeled walker with seat, adequately support her mobility and ADLs. Respondent further found that introduction of a mobility scooter would risk further

deconditioning, decreased endurance, and long-term functional decline.

Petitioner offers an extensive and vivid description of her daily struggles, including pain, instability, muscle fatigue, and emotional distress. Her statements communicate a genuine and profound sense of physical limitation and psychological burden, and the tribunal acknowledges the authenticity and seriousness of her lived experience.

Petitioner argues that a mobility scooter would:

- Provide stability (“scooter-legs”),
- Reduce fatigue,
- Mitigate pain while walking or sitting,
- Improve emotional health,
- Reduce fall risk, and
- Restore dignity and independence.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying her request for a power mobility device. Based on the above evidence presented, this Administrative Law Judge finds that Petitioner has failed to meet this burden of proof.

Under the applicable regulatory framework, an assistive device such as a mobility scooter must be demonstrated to be medically necessary, meaning reasonably expected to improve, maintain, or prevent deterioration of functional capacity, and not merely to enhance convenience or general quality of life. Furthermore, according to the above policy, power mobility devices are approved only if the device will help with ADLs in the home.

Here, substantial evidence supports the conclusion that Petitioner retains functional ambulation capacity with a walker, can independently perform essential ADLs, and demonstrates adequate strength, balance, and stability to ambulate safely with existing assistive devices, as documented by PT and OT evaluations. These objective findings weigh against classification of a mobility scooter as medically necessary.

Evidence also supports Respondent’s determination that use of a scooter would likely reduce Petitioner's remaining physical activity, thereby increasing the risk of deconditioning and further loss of functional mobility, which contravenes the medical necessity standard.

While Petitioner provides a compelling and sincere narrative describing her pain, fatigue, emotional distress, and desire for improved quality of life, medical necessity determinations must rely primarily on clinical functional evaluation, not subjective preference or psychological benefit alone.

Petitioner's emotional and psychological concerns, while significant, can be addressed through counseling services, and Respondent is not required under applicable standards to authorize mobility equipment solely to support emotional well-being when functional criteria are not met.

Petitioner's arguments are sincere and compelling, but they do not overcome the clinical findings documented by Respondent's multidisciplinary team. Those findings include:

- No observed loss of balance during evaluation,
- Independent functional mobility within the home,
- Ability to ambulate meaningful distances with a walker,
- Ability to perform ADLs with minimal or no assistance, and
- Adequate pain control.

The assessments do not support the objective level of impairment asserted by Petitioner, despite her subjective experience of difficulty. The law requires that durable medical equipment be warranted by functional necessity, not merely improvement of comfort, convenience, or quality of life.

Thus, while Petitioner's argument highlights important personal and emotional dimensions, the legal standard requires that the decision turn on the objective clinical record, which favors Respondent.

As such, Respondent's decision was supported by substantial evidence in the administrative record and was neither arbitrary nor capricious.

Accordingly, this Administrative Law Judge finds that Petitioner has failed to prove, by a preponderance of the evidence, that Respondent's denial was improper.

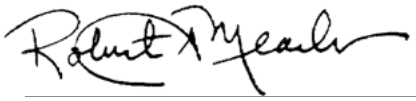
If Petitioner's condition has further deteriorated since the original denial, which occurred five months ago, she can always make a new request for a power scooter and undergo a new evaluation.

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 a power mobility device.

IT IS THEREFORE ORDERED that:

The Respondent's decision is **AFFIRMED**.



ROBERT J. MEADE
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to LARA-MOAHR-DCH@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

Via First Class & Electronic Mail:

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