

## 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. On November 19, 2025, Petitioner requested a power scooter. The request was presented to Respondent's Interdisciplinary Team on November 21, 2025, as a Service Determination Request. (Exhibit A, pp 7, 12; Testimony)
4. Respondent's Occupational Therapist assessed Petitioner and documented, among other things, that Petitioner:
  - Uses a high-back reclining wheelchair with right residual limb support and requires extensive assistance to manage or propel the wheelchair. (Exhibit A, pp 7, 39; Testimony)
  - Lacks trunk and sitting balance sufficient for unsupported sitting in a scooter, has difficulty repositioning, and is at high risk for sliding down or falling out. (Exhibit A, pp 8, 40; Testimony)
  - Requires a Hoyer lift for all transfers and would be unable to transfer on or off a power scooter independently. (Exhibit A, pp 8, 40; Testimony)
  - Has limited right-hand range of motion and fine motor function related to prior TIA, decreased safety awareness and problem solving, and limited vision from glaucoma and cataracts raising risk of collision or roadway hazards. (Exhibit A, pp 8, 40; Testimony)
  - Lives in a home environment with space limitations that do not allow for safe scooter use or storage. (Exhibit A, pp 8, 12, 40; Testimony)

The OT concluded a power scooter was not necessary to meet Petitioner's needs and posed more negative outcomes than benefits to her overall health status. (Exhibit A, pp 8, 40; Testimony)

5. On November 21, 2025, Respondent denied the request, stating the power scooter was not necessary to meet Petitioner's medical, physical, emotional, or social needs and increased risk of injury to Petitioner and others. The notice advised Petitioner of internal and external appeal rights. (Exhibit A, pp 9–11, 42–44; Testimony)
6. On December 22, 2025, Petitioner's spouse submitted a statement asserting Petitioner could operate the scooter with her "operating hand," had strength in both hands, sat upright with back support, and that a swivel seat would allow a nurse's aide to transfer her into the scooter despite Hoyer lift use. (Exhibit A, p 18; Testimony)
7. The face sheet and care plan reflect Petitioner's extensive comorbidities, including dialysis three times weekly, oxygen dependence, wheelchair dependence, right above-knee amputation, left foot ulcer history, glaucoma, vascular dementia, and reliance on home care for activities of daily living. (Exhibit A, pp 19–37, 32–37; Testimony)
8. PT and OT documentation across 2025 shows Petitioner requires a Hoyer lift for transfers, demonstrates fair or impaired unsupported sitting balance, experiences fatigue, and needs moderate to maximum assistance for sliding board transfers and wheelchair positioning. Vision issues and right-hand limitations are noted, and therapy participation was intermittent. (Exhibit A, pp 51–66, 67–73, 75; Testimony)
9. On January 6, 2026, Respondent's internal appeals committee reviewed the record and unanimously upheld the denial, citing safety concerns related to vision, hand placement, and poor balance; the committee determined Petitioner would continue to benefit most from the high-back reclining wheelchair for home and community mobility. (Exhibit A, p 76; Testimony)
10. On February 4, 2026, the Michigan Office of Administrative Hearings and Rules (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  
October 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  
October 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  
October 1, 2025, p 110*

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 evidence presented, this Administrative Law Judge finds that Petitioner has failed to meet this burden of proof.

Respondent's IDT Regulatory Advisor stated that Petitioner requested a power scooter on November 19, 2025. The Interdisciplinary Team reviewed the request on November 21, 2025, and the occupational therapy assessment led to a denial. Petitioner pursued an internal appeal, which was also denied.

Respondent's Occupational Therapist (OT) testified regarding her assessment. She stated that Petitioner was unable to maintain the unsupported sitting balance required to safely operate a scooter.

She described right upper extremity range of motion limitations, coordination deficits, trunk and cervical range of motion limitations, and vision limitations, including cataracts. She testified that Petitioner had difficulty repositioning herself, lacked endurance, and was at risk of sliding out of a scooter. Based on these safety concerns, she recommended denial.

Petitioner's husband expressed frustration about the process and disputed some statements in Exhibit A. He said they were not trying to obtain a scooter for independent community travel but rather wanted her to have a chair that could help motivate her to improve. He acknowledged that she could not operate it independently at this time and stated he would not let her ride it unsafely. He emphasized that their request was motivated by a desire for improvement and quality of life.

Petitioner spoke briefly, expressing frustration with her medical experiences and stating that she believed she could use a scooter with her functioning hand. She noted that she practiced skills independently at home.

Petitioner's sister REDACTED stated that Petitioner could sit on the side of the bed and was not as impaired as suggested. She believed Petitioner could use a scooter if given proper support and the right model. She emphasized that Petitioner would always have someone with her when using it.

Petitioner's sister REDACTED said Petitioner had upper body strength and could improve further with consistent physical therapy. She noted that Petitioner often waited long periods for therapy at the center. She believed Petitioner could use a scooter, particularly if designed for left hand operation, and reiterated that Petitioner would not go out alone. She also stressed that the scooter would motivate Petitioner emotionally and give her something to work toward.

In this matter, the central question is whether Respondent's denial of a power scooter was consistent with the applicable standards of medical necessity and safety, as documented in the clinical record and care plan. The record establishes that Petitioner's mobility and safety profile is characterized by the following: reliance on a Hoyer lift for all transfers, limited trunk and sitting balance, limited right hand range of motion and fine motor function secondary to TIA history, oxygen dependence, significant visual impairment due to glaucoma and cataracts, cognitive limitations including decreased safety awareness and problem solving, and a home environment with space constraints. These findings directly relate to the safe operation and transfer requirements associated with a power scooter and materially increase risk of falls, collision, and injury. (Exhibit A, pp 8, 40, 51–56, 67–73)

Petitioner's argument that she could operate the scooter with her "operating hand," sit upright with back support, and use a swivel seat with assistance does not overcome the documented clinical limitations. The record shows impaired unsupported sitting balance and a need for extensive assistance even with sliding board transfers, indicating that stable, independent seating and repositioning on a scooter would be unsafe.

The documented right-hand range of motion and coordination deficits undermine the assertion of sufficient bilateral hand strength and controlled hand function for safe scooter driving, braking, and steering. Further, a swivel seat does not eliminate the requirement for safe, controlled transfers and postural stability once seated; Petitioner's reliance on a Hoyer lift and her poor dynamic sitting balance make such transfers and subsequent scooter operation high risk. Finally, visual impairment and decreased safety awareness independently elevate risk in community environments where rapid decisions and hazard recognition are required. (Exhibit A, pp 18, 8, 40, 52–56, 67–73)

The Occupational Therapy assessment concluded that a power scooter was not necessary to meet Petitioner's needs and posed more negative outcomes than benefits to her health status. The internal appeals committee independently reviewed the record and unanimously agreed, citing vision, hand placement, and poor balance. The evidence

is consistent and persuasive across disciplines and time, and it supports Respondent's determination that Petitioner's current high-back reclining wheelchair, used with assistance, remains the safest and most appropriate mobility solution for home and community use. (Exhibit A, pp 8, 40, 76)

Petitioner and her family presented several arguments at the hearing. They stated that Petitioner could improve with therapy, could sit on the edge of the bed, might be able to operate a scooter using her left hand, and would always have assistance from family when using it. They also emphasized that the scooter would motivate her and increase her quality of life. Petitioner's husband further argued that the denial was unfair and that the family was not seeking immediate independent use.

However, these arguments do not overcome the documented clinical safety risks identified by the occupational therapist. The safety concerns at the time of assessment included limited sitting balance, limited trunk control, impaired right hand function, impaired vision, difficulty repositioning, and reliance on a Hoyer lift for all transfers. These factors directly affect safe operation of any power scooter regardless of the presence of family members. Operation of a motorized device requires independent ability to maintain posture, control speed, brake, and respond quickly to hazards. Petitioner's current limitations substantially increase her risk of falling, sliding, or colliding with obstacles.

The family's emphasis on long term goals and motivation does not alter the medical necessity analysis. The testimony confirms that Petitioner is not physically ready to use a scooter at this time and that even her family would not place her in one now. Motivation, future progress, and emotional benefit cannot substitute for the functional ability and safety capability required today. Respondent's obligation is to determine medical necessity and safety based on current clinical findings, not hoped for future improvement.

Petitioner also argued that some statements in Exhibit A were inaccurate. Even if some disagreements exist, the comprehensive documentation consistently shows significant mobility, strength, balance, and vision deficits. The internal appeal committee also independently reviewed the evidence and unanimously upheld the denial.

Accordingly, Respondent demonstrated that the requested power scooter is not medically necessary for Petitioner and that its denial was grounded in clinical safety considerations and an individualized assessment of Petitioner's functional status. (Exhibit A, pp 7-8, 39-40, 51-56, 67-73, 76). As such, Petitioner failed to meet her burden.

If Petitioner's strength improves through continued therapy, 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**.