**STATE OF MICHIGAN**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Docket No. 2010-17482 PA
Case No. [redacted]

[redacted],

Appellant
______________________/

## DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, following the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]

The Appellant was represented by [redacted]

The Department of Community Health was represented by [redacted], Appeals and Review Officer. [redacted], [redacted], appeared as a witness on behalf of the Department.

## ISSUE

Did the Department properly deny the Appellant's request for coverage of the nutritional supplements Ensure Plus and protein powder?

## FINDINGS OF FACT

Based upon the competent, material and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. The Appellant is a [redacted] year old woman who is a Medicaid beneficiary.

2. The Appellant is diagnosed with end stage renal disease, diabetes, esophageal reflux and high blood pressure. She is taking dialysis.

3. The Appellant is wheelchair bound.

4. The Appellant suffers chronic hypo-albuminemia secondary to her ESRD. She has a medical need for 2010-2345 calories per day, which must include between 74-94 grams of protein.

5. The Appellant's prior authorization request indicates she has a poor appetite and limited intake, resulting in her inability to obtain the nutrients she need from food consumption.

6. Ensure Plus is a liquid nutritional supplement.

7. A prior authorization request was made for protein powder that can be added to food or to liquids and Ensure Plus.

8. Following review of medical documentation of the Appellant's nutritional status and needs, as prepared by her physician's assistant, the Department denied the request for prior authorization on [redacted].

9. On [redacted], the Appellant filed a Request for Hearing with the State Office of Administrative Hearings and Rules.

**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.

> The Medicaid Provider Manual addresses the need for prior authorization in the General Information for Providers Chapter at Section 8-Prior Authorization.
>
> **8.1 General Information**
>
> There may be occasions when a beneficiary requires services beyond those ordinarily covered by Medicaid or needs a service that requires prior authorization (PA). In order for Medicaid to reimburse the provider in this situation, MDCH requires that the provider obtain authorization for these services before the service is rendered. Providers should refer to their provider-specific chapter for the PA requirements.
>
> The Medical Supplier Chapter addresses the PA requirements for medical equipment requests. It states in pertinent part:

**1.7 Prior authorization**

Prior authorization (PA) is required for certain items before the item is provided to the beneficiary or, in the case of custom-made DME or prosthetic/orthotic appliance, before the item is ordered. To determine if a specific service requires PA, refer to the Coverage Conditions and Requirements Section of this chapter and/or the MDCH Medical Supplier Database on the MDCH website.

PA will be required in the following situations:

- Services that exceed quantity/frequency limits or established fee screen.
- Medical need for an item beyond MDCH's Standards of Coverage.
- Use of a Not Otherwise Classified (NOC) code.
- More costly service for which a less costly alternative may exist.
- Procedures indicating PA is required on the MDCH Medical Supplier Database.

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**1.5 MEDICAL NECESSITY**

Services are covered if they are the most cost-effective treatment available and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter. A service is determined to be medically necessary if prescribed by a physician and it is:

- Within applicable federal and state laws, rules, regulations, and MDCH promulgated policies.
- Medically appropriate and necessary to treat a specific medical diagnosis or medical condition, or functional need.
- Within accepted medical standards; practice guidelines related to type, frequency, and duration of treatment; and within scope of current medical practice.
- Inappropriate to use a nonmedical item.
- The most cost effective treatment available.

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**1.10 NONCOVERED ITEMS**

Items that are not covered by Medicaid include, but are not limited to:

- Adaptive equipment (e.g., rocker knife, swivel spoon, etc.)
- Air conditioner
- Air purifier
- **Enteral formula to accommodate psychological or behavioral conditions, food preferences, allergies, loss of appetite, or noncompliance with a specialized diet**
- Environmental Control Units
- Equipment not used or not used properly by the beneficiary
- Equipment for social or recreational purposes
- Exam tables/massage tables
- Exercise equipment (e.g., tricycles, exercise bikes, weights, mat/mat tables, etc.)
- Generators
- Hand/body wash
- Heating pads
- Home modifications
- Hot tubs
- House/room humidifier
- Ice packs
- Items for a beneficiary who is non-compliant with a physician's plan of care (or) items ordered for the purpose of solving problems related to noncompliance (e.g., insulin pump)
- Items used solely for the purpose of restraining the beneficiary for behavioral or other reasons
- Lift chairs, reclining chairs, vibrating chairs
- More than one pair of shoes on the same date of service
- New equipment when current equipment can be modified to accommodate growth
- Nutritional formula representing only a liquid form of food
- Nutritional puddings/bars
- Over-the-counter shoe inserts
- Peri-wash

- Portable oxygen, when oxygen is ordered to be used at night only
- Power tilt-in-space or reclining wheelchairs for a long-term care resident because there is limited staffing
- Pressure gradient garments for maternity-related edema
- Prosthetic appliances for a beneficiary with a potential functional level of K0
- Regular or dietetic foods (e.g., Slimfast, Carnation instant breakfast, etc.)
- Room dehumidifiers
- School Items (e.g., computers, writing aids, book holder, mouse emulator, etc.)
- Second units for school use
- Second wheelchair for beneficiary preference or convenience
- Sensory Devices (e.g., games, toys, etc.)
- Sports drinks/juices
- Stair lifts
- Standard infant/toddler formula
- Therapy modalities (bolsters, physio-rolls, therapy balls, jett mobile)
- Thickeners for foods or liquids (e.g., Thick – it)
- Toothettes
- Transcutaneous Nerve Stimulator when prescribed for headaches, visceral abdominal pain, pelvic pain, or temporal mandibular joint (TMJ) pain
- Ultrasonic osteogenesis stimulators
- UV lighting for Seasonal Affective Disorder
- Vacu-brush toothbrushes
- Weight loss or "light" products
- Wheelchair lifts or ramps for home or vehicle (all types)
- Wheelchair accessories (e.g., horns, lights, bags, special colors, etc.)
- Wigs for hair loss

For specific procedure codes that are not covered, refer to the MDCH Medical Supplier Database on the MDCH website or the Coverage Conditions and Requirements Section of this chapter. (emphasis added by ALJ)

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**2.13.A Enteral Nutition (Administered Orally)**

**Standards of Coverage**

Enteral nutrition (administered orally) may be covered for beneficiaries under the age of 21 when:

- A chronic medical condition exists in nutritional deficiencies and a three month trial is required to prevent gastric placement.
- Supplemental to regular diet or meal replacement is required, and the beneficiary's weight-to-height ratio has fallen below the fifth percentile on standard growth grids.
- Physician documentation details low percentage increase in growth pattern or trend directly related to the nutritional intake and associated diagnosis/medical condition.

For CHSCS coverage, a nutritionist or appropriate subspecialist must indicate that long-term enteral supplementation is required to eliminate serious impact on growth and development.

For beneficiaries age 21 and over:

- The beneficiary must have a medical condition that requires the unique composition of the formulae nutrients that the beneficiary is unable to obtain from food
- The nutritional composition of the formulae represents an integral part of treatment of the specified diagnosis/medical condition.
- The beneficiary has experienced significant weight loss.

**Documentation**

Documentation must be less than 30 days old and include:

- Specific diagnosis/medical condition related to the beneficiary's inability to take or eat food
- Duration of need
- Amount of calories needed per day

- Current height and weight, as well as change over time. (for beneficiaries under 21, weight-to-height ratio)
- Specific prescription identifying levels of individual nutrient(s) that is required in increased or restricted amounts.
- List of economic alternatives that have been tried
- Current laboratory values for albumin or total protein (for beneficiaries age 21 and over only).

For continued use beyond 3-6 months, the CHSCS Program requires a report from a nutritionist or appropriate pediatric subspecialist.

**PA Requirements**
PA is required for all enteral formulae for oral administration.

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This ALJ reviewed the evidence of record to determine whether the Standards of Coverage were met with the documentation submitted. The Department did cite the lack of physician signature on the request made, although it further testified about the substantive reason the request did not meet the Standards of Coverage in the Medicaid provider manual. The Department witness stated the Appellant's documentation did show some weight loss, but it was unable to discern whether the weight loss was attributable to fluid exchange or not. Furthermore, her BMI was within normal limits. Additionally, the Department witness asserted there is no indication that sufficient nutrients could not be obtained from food and the policy does not provide coverage for poor appetite.

On behalf of the Appellant, it was indicated she has a very low albumin level. Furthermore, her weight loss is over 9% of her body weight. The Department cites the Appellant's BMI when addressing the Standards of Coverage relative to weight loss. This ALJ notes the Standards of Coverage do not state a BMI within normal limits precludes coverage of the nutritional supplement sought. It states the beneficiary has experienced significant weight loss. While addressing the BMI may be a valid way means of determining whether weight loss recently incurred is indeed significant or not, this ALJ is reluctant to find someone has not suffered significant weight loss simply because their BMI is still within normal limits. At age with ESRD and diabetes among the medical conditions suffered, a loss of 9% of body weight within a few month time period is found significant by this ALJ.

Having found the Appellant did incur a significant weight loss is an insufficient basis upon which to reverse the Department in this case, however. The evidence of record is uncontested specifically regarding the issue of whether the formula requested is specifically or uniquely designed to provide the nutrients the Appellant is unable to obtain from food. The formula requested is a standard formula, not specific to renal patients. Another

shortcoming of the documentation submitted is that the reason the alternatives have failed is not actually provided. Her documentation states she has tried snacks and small frequent meals. However, it does not state why these alternatives have failed or indeed, that they actually have failed.

This ALJ was concerned for the Appellant's medical and nutritional status, however, is required to apply the policy as written. The Department of Community Health has enacted a very strict policy pertaining to approval for supplements. Not only do the Standards of Coverage have to be met, but once the Standards of Coverage are satisfied, it must not be excluded from coverage under non-covered items.

When reviewing the documentation and testimony in evidence, this ALJ could not find the evidence needed to establish all Standards of Coverage had been met, therefore, this ALJ is forced to sustain the Department's denial. Based upon the Standards of Coverage for the supplement requested, the above findings of fact and conclusions of law, I find the Department's denial of coverage for both the protein powder and Ensure Plus were supported by its own policy.

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: 4/22/2010

***** NOTICE *****
The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.