STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2010-31856 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 Mr. Jeffery Hart.

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

ISSUE

Did the Department properly deny the Appellant's request for coverage of the nutritional supplement Boost ?

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 male who is a Medicaid beneficiary.

2. The Appellant has survived cancer of the larynx and has prothesis placement for his throat. He reports difficulty swallowing.

3. The Appellant has consumed Boost for seven (7) years and maintained his weight at 140lbs.

4. The Appellant's doctor prescribed Boost on or about [redacted]. The prescription indicates it is need to rebuild bone and blood cells.

5. A request for prior authorization was submitted to the Department, using the [redacted] prescription, on or about [redacted].

6. Following review of the documentation submitted, including that sent following a request for additional information, the Department denied the request for prior authorization on [redacted].

7. 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.

Medicaid provider Manual
Version Date January 1, 2010
Medical Supplier Chapter Page 7

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.

Version Medical Supplier
Date: January 1, 2010
Page 3

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)

Version Medical Supplier
Date: January 1, 2010
Page 15

2.13.A Enteral Nutition (Administered Orally)

Standards of Coverage

Enteral nutition (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.

Version Medical Supplier
Date: January 1, 2010
Page 15

This ALJ reviewed the evidence of record to determine whether the Standards of Coverage were met with the documentation submitted. While there is uncontested evidence the Appellant has survived throat cancer and has placement of a prothesis for swallowing, it is uncontested he is able to take in food orally. He can take in pureed and softer foods, such as eggs and grits according to the uncontested testimony provided at hearing. There is no documentation he cannot increase his calories through this means. While he has relied on use of this product for his nutritional needs for several years according to his own written statement, this reliance does not evidence he meets the standards of coverage and documentation requirements. This ALJ is aware that his medical condition is not materially different than in the past where he has received the prior authorization sought, however, the Department is entitled to correct its own errors. Here, there is no documentation that evidences he has experienced significant weight loss. Furthermore, it is not shown that he has a need for the specific nutritional formulae contained in Boost. The product is available over the counter without a prescription and not designated for his specific medical diagnosis.

This ALJ is sympathetic to the Appellant's medical condition and past reliance on this product to supplement his caloric intake, however, is restricted to application of the policy published in the Medicaid Provider Manual and must strictly apply the provisions therein. The authority of this ALJ does not include equitable jurisdiction.

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

[redacted]
Docket No. 2010-31856 PA
Decision and Order

cc: [redacted]

Date Mailed: 7/16/2010

***** 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.