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. 2010-40567 QHP
Case No [redacted]

[redacted],

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge 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 on [redacted]. The Appellant represented herself. [redacted] Director of Customer and Provider Services, represented [redacted] the Medicaid Health Plan (MHP). [redacted], Nurse Case Manager, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for coverage of the nutritional supplement Ensure Plus?

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] female Medicaid beneficiary.

2. The Appellant has been diagnosed with AIDS and is required to take 18 medications daily. (Testimony of Powers)

3. The Appellant drinks the nutritional supplement requested, Ensure Plus, with her medications to keep from throwing them up. (Testimony of [redacted])

4. The MHP received the request for prior authorization of the nutritional supplement on [redacted]. (Exhibit 1, page 6)

5. On the prior-authorization request, the Appellant's weight was noted as 152 pounds and her height as 65 inches. (Exhibit 1, page 6)

6. The MHP contacted the provider for additional information regarding the Appellant's need for the nutritional supplement. No additional information was received. (Exhibit 1, page 1)

7. The MHP denied the request for prior authorization on [redacted] because "[n]utritional supplements to maintain weight and strength are not covered, " the Appellant is able to ingest food normally, and the Appellant is able to maintain a normal weight. (Exhibit 1, page 10)

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

9. On [redacted], the MHP received a report from the Appellant's primary care physician (PCP), which indicated that the Appellant's weight and BMI are meeting the required standards. And long as she can meet her nutritional requirements from her regular diet, Ensure Plus is not necessary. (Exhibit 1, page 15).

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.

On May 30, 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified MHPs.

The Respondent is one of those MHPs.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if

services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 2.024.

Section 1.022(E)(1), Covered Services.
MDCH contract (Contract) with the Medicaid Health Plans,
October 1, 2009.

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

(a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.

(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.

(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.

(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.

(e) The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure
The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM

> decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
>
> *Section 1.022(AA), Utilization Management, Contract, October 1, 2009.*

As stated in the Department-MHP contract language above, an MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent sections of the Michigan Medicaid Provider Manual (MPM) state as follows:

> **1.10 NONCOVERED ITEMS**
> Items that are not covered by Medicaid include, but are not limited to:
>
> * * *
>
> - Enteral formula to accommodate psychological or behavioral conditions, food preferences, allergies, loss of appetite, or noncompliance with a specialized diet
>
> *Michigan Department of Community Health*
> *Medicaid Provider Manual*
> *Medical Supplier; April 1, 2010;*
> *Page 14*

> **2.13.A Enteral Nutition (Administered Orally)**
>
> **Standards of Coverage**
>
> * * *
>
> 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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The MHP witness explained that the nutritional supplement in this case was denied because the Appellant is capable of ingesting regular foods and she is maintaining a normal weight. She referred this ALJ to the MHP's internal policy regarding enteral nutrition, which states: "Nutritional supplements such as Ensure for patients capable of ingesting normally, even if required to maintain weight and strength, are not covered." (Exhibit 1, page 13) However, the MHP witness noted that exceptions may be made to that policy where there is a BMI lower than 19, but that is not the case here.

The Appellant testified that she is able to ingest regular food. However, she stated that she needs the nutritional supplement to take her medications. She stated that if she does not take her medications with the Ensure Plus, she throws all of them up. She further testified that she has an appetite problem, and if she does not take her medications, she has no desire to eat. Finally, the Appellant testified that she has lost 50 pounds, 11 of which were lost in a month.

While this ALJ sympathizes with the Appellant's situation, she does not meet the criteria for authorization of Ensure Plus. She is able to ingest regular foods and maintain a normal weight, and her treating physician stated that there was no need for the nutritional supplement. Accordingly, the MHP's denial was proper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for Ensure Plus.

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Mailed: 9/17/2010

***** 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.