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:

[redacted]

Appellant

_____/

Docket No. 2011-13473 PA
Case No. 2694747

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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared on behalf of the Appellant. He had no witnesses. [redacted], represented the Department. Her witness was [redacted], [redacted].

ISSUE

Did the Department properly deny Appellant's prior authorization (PA) request for Ensure?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

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

2. The Appellant is diagnosed with dysphagia, DD, cognitive impairment, tracheostomy, Hunter syndrome, reactive airway disease, obstructive sleep apnea and asthma. He is followed at the [redacted].

3. As of [redacted], the Appellant was on a "regular diet" on discharge from the [redacted] at the [redacted]. (Department's Exhibit A, p. 14)

4. The Appellant was determined to eat in an untimely manner and was perceived to have had a decreased appetite during the calendar year [redacted]. (See Testimony of Appellant's representative and Department's

Exhibit A, at page 18)

5. As of [redacted], Dr. [redacted], recommended that the Appellant "clearly needs" to continue consumption of 8 ounces of Ensure per day because "…his weight is stable – [but] it is not increasing." (Department's Exhibit A, p. 24)

6. Following review of medical documentation, as submitted, the Department denied the request for prior authorization, because the rational of expediting feeding time does not meet the Medicaid standard of coverage or medical necessity. (Department's Exhibit A, pp. 3, 4)

7. The Department noted that the Appellant's weight had increased from [redacted] and that his BMI was in the 75th percentile. (Department's Exhibit A, p. 3)

8. Thereafter, on [redacted], the Department sent a denial notice to the Appellant. His further appeal rights were contained therein. (Department's Exhibit A, pp. 3, 4)

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 (MPM) addresses the need for prior authorization in the General Information for Providers Chapter at Section 9 and the Prior Authorization sections in the Medical Supplier chapter to follow below**:**

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.

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.

MPM, Medical Supplier, §1.7, January 1, 2011, p. 8

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.

MPM, *Supra*, §1.5, page 4

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

[Procedure Codes omitted by ALJ]

MPM, *Supra*, §1.10. pp.16-18

Enteral Nutrition (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 tube 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. (Emphasis supplied)
>
> ****
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> MPM, *Supra*, §2.13.A, pp. 16-18

This ALJ reviewed the evidence and the testimony to determine whether the Standards of Coverage were met with the documentation submitted. There is no evidence that the Appellant meets the Standards of Coverage for the product requested. Specifically, he no longer has a medical condition that requires the unique composition of the nutrients that the he is unable to obtain from food.

Furthermore, the Department witness observed that the Appellant's information is outdated and lacked a required food diary – the omission of which was also referenced in the [redacted] records submitted for review.

The Appellant's representative said that the necessity for Ensure was [now] to stave off insertion of a G-tube for feeding and so the Appellant would receive necessary vitamins.

The Department witness testified that she could not change the documentation to reflect such a change in condition - but provided the Appellant's representative with a telephone number for their physican to contact MPRO to revisit authorization of Ensure owing to a change in condition.

On review, it appears that the medical basis for the Appellant's need for Ensure has changed – now instead of being necessary for weight gain or weight stability it is medically necessary for the Appellant to consume Ensure for vitamins and avoidance of a G-tube. The medical evidence submitted in [redacted] with this appeal, unfortunately, does not support such a change in condition. This information must be provided to the

Department in order to satisfy coverage requirements under the Medicaid Provider Manual.

There is no basis for upon which this ALJ could find that the Appellant meets the Standards of Coverage. The Appellant has failed to preponderate his burden of proof.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4/1/2011

***** 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 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.