

**STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
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. 2012-26988 QHP

██████████

██████████

██████████

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 ██████████. The Appellant was represented by ██████████ (Appellant's mother). Priority Health was represented by ██████████ Medicaid Appeals.

**ISSUE**

Did Priority Health 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 ██████ year old male who is a Medicaid beneficiary.
2. The Appellant is diagnosed with Attention Deficit Hyperactive Disorder. The Appellant is treated with Adderall.
3. The Appellant's physician increased the Appellant's Adderall dose to respond to changes in the Appellant's behavior.
4. Adderall can cause weight loss for some users.
5. On ██████████, the Appellant was ██████ in height and weighed ██████ pounds.

6. On [REDACTED], Priority Health received a prior authorization request from Airway Oxygen Inc for the nutritional supplement Boost. The Appellant's physician, [REDACTED], ordered the Boost to treat the Appellant's weight loss.
7. Priority Health staff reviewed the prior authorization request and on [REDACTED], informed the Appellant through an adequate action notice that his request for Boost was denied.
8. On [REDACTED], the Michigan Administrative Hearing System received the Appellant's request for hearing.

### **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 Medicaid Health Plans.

The Respondent is one of those Medicaid Health Plans.

The Covered Services that the Contractor has available for Enrollees must include, at a minimum, the Covered Services listed below. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors 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 I-Z.

Although the Contractor must provide the full range of Covered Services listed below they may choose to provide services over and above those specified.

The services provided to Enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid EPSDT policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services for individuals under age 21
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and supplies
- Emergency services
- End Stage Renal Disease services
- Family Planning Services
- Health education
- Hearing & speech services,
- Hearing aids for individuals under age 21
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Maternal and Infant Support Services (MSS/ISS)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per Contract year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially, pregnancy related and well-child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services for individuals under age 21
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics & orthotics

- Therapies, (speech, language, physical, occupational)
- Transplant services
- Transportation
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSTD for persons under 21.

Article II-G. Scope of Comprehensive Benefit Package, contract  
with qualified managed health care plans  
November 6, 2007, p. 32.

The MDCH-MHP contract language allows a health plan such as ██████████ to limit services to those that are medically necessary and consistent with Medicaid policy. Priority Health's Utilization Guidelines are nearly identical to the Medicaid Provider Manual criteria for enteral formula and are as follows:

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

- A chronic medical condition exists resulting in nutritional deficiencies and a three month trial is required to prevent gastric tube placement.
- Supplementation 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 CSHCS coverage**, a nutritionist or appropriate pediatric subspecialist must indicate that long-term enteral supplementation is required to eliminate serious impact on growth and development.

#### **Standards of Coverage**

For beneficiaries age 21 and over:

- The beneficiary must have a medical condition that requires the unique composition of the formula nutrients that the beneficiary is unable to obtain from food.
- The nutritional composition of the formula 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 CSHCS Program requires** a report from a nutritionist or appropriate pediatric subspecialist.

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

*Medical Provider Manual, Medical Supplier,  
Section 2.13, pp. 31-33. Online pp. 711-712*

### **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)

Medicaid Provider Manual, Medical Supplier Section 1.10, Date: January 1, 2012, pp. 16-17, online pp. 696-698.

The following facts are not in dispute. The Appellant is diagnosed with ADHD and his physician has prescribed Adderall. The Appellant's physician increased the Appellant's Adderall dose to address changes in the Appellant's behavior. The Appellant's weight began to decline due in part to the increase in the Appellant's Adderall dose. The Appellant's physician, ██████████, submitted a prior authorization request through a Medical Supplier, Airway Oxygen Inc. for the nutritional supplement Boost. Priority Health reviewed the request and then denied the request because the Appellant did not meet Priority Health and Medicaid coverage criteria.

██████████ testified for Priority Health that the Appellant's physician submitted the request for Boost to address the Appellant's weight loss. ██████████ further testified that the Appellant's height to weight ratio is above the fifth percentile on standard growth grids.

██████████ testified that the documentation provided indicated that the Appellant's physician requested Boost to treat the Appellant's weight loss due to an increase in the Appellant's medications. ██████████ testified that Medicaid covered nutritional supplements are not available to treat medication side effects.

██████████ also testified that no medical evidence was provided which shows that the Appellant has a chronic medical condition which has resulted in a nutritional deficiency that places the Appellant at risk of tube feeding. In addition, ██████████ testified that no documentation was provided which shows that the Appellant's growth is limited by a nutritional deficiency or decrease in his growth. ██████████ testified that the only reason given for the prior authorization request was the Appellant's medication related weight loss. ██████████ finally testified that the Appellant's medication related weight loss does not meet Medicaid coverage criteria. Medicaid policy in the Medical Supplier Chapter provides in section 1.10 that "Enteral formula to accommodate psychological or behavioral conditions, food preferences, allergies, loss of appetite, or noncompliance with a specialized diet."

The Appellant's mother testified that the Appellant's behavior declined and the Appellant's physician increased the Appellant's medication. Shortly thereafter the Appellant began to lose weight. The Appellant's mother testified that she understood the Medicaid policy but thought because the Appellant's physician had prescribed Boost that Medicaid would cover the cost.

The evidence presented shows that the Appellant's medication increase resulted in weight loss. The Medicaid coverage criteria for nutritional supplements do not allow Medicaid coverage for medication related weight loss. Therefore, the Department properly applied applicable Medicaid policy and properly denied the Appellant's prior authorization request.

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.


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Martin D. Snider  
Administrative Law Judge  
For Olga Dazzo, Director  
Michigan Department of Community Health

cc: ██████████  
██████████

Date Mailed: 3-20-12



  
Docket No. 2012-26988 QHP  
Decision and Order

**\*\*\* NOTICE \*\*\***

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.

