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:

[redacted],

Docket No. 2012-30746 QHP [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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant appeared without representation. She had no witnesses. [redacted], Hearings Coordinator, represented the MHP. Her witness was Dr. [redacted], Medical Director.

ISSUE

Did the MHP properly deny the Appellant's request for coverage of the nutritional supplement [redacted]?

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 female Medicaid beneficiary.

2. The Appellant is afflicted with pancreatic cancer and is undergoing chemo-therapy and radiation treatments as well. (Respondent's Exhibit A, page 1 and Appellant's Exhibit #1)

3. The Appellant seeks the nutritional supplement Ensure to battle the after effects of her cancer treatments as well as dehydration. (Appellant's Exhibit #1)

4. The MHP received the request for prior authorization of the nutritional supplement on [redacted]. (Respondent Exhibit A, pp. 2 and 9)

5. On the prior-authorization request, the Appellant's condition was identified as NEOPLASM PANCREAS Code 157.9. The Active Infusion Center identified [redacted] requirements for authorization of Ensure and forwarded that information back to the requesting physican. (Respondent's Exhibit A, pp. 9 and 11)

6. The requested documentation was never received by [redacted]. (See Testimony [redacted] and Respondent's Exhibit A, p. 11)

7. The MHP denied the request for prior authorization on [redacted], for lack of documentation of need. (Respondent's Exhibit A, p. 1)

8. On [redacted] the provider and the Appellant were advised of both the denial and their further appeal rights. (Respondent's Exhibit A, pp. 2 – 5)

9. The instant appeal was received by the Michigan Administrative Hearing System (MAHS) for the Department of Community Health on [redacted]. (Appellant's Exhibit #1)

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. 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.

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 covered 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 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- 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)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar 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
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2010, p. 22.

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

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- 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.
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> ***
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> Contract, *Supra,* p. 49.

As stated in the Department-MHP contract language above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The Medicaid Provider Manual states as follows:

> **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
>
> Medicaid Provider Manual (MPM) §1.10**,**
> Medical Supplier; April 1, 2012 at pages 16-17

> **Enteral Nutrition (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 formula for oral administration.

MPM, §2.13. A, Medical Supplier,
April 1, 2012, pp. 31, 32

***

The MHP witness explained that the nutritional supplement in this case was denied because there was no evidence (in doctor notes) that the Appellant was not capable of ingesting regular foods or that she has a medical need for the unique composition of the formula nutrients found in the product [redacted]

She said the MHP, as of the date of hearing, still did not have documentation: 1) that the member had a medical condition that required the unique composition of the formula of the nutrients that the member is unable to obtain from food, 2) the nutritional composition of the formula represents an integral part of treatment of the specified diagnosis, or 3) the member has experienced significant weight loss.[1]

The Appellant testified that she was unaware of the internal appeal process and that the MHP somehow obtained the records from the wrong doctor. She identified her doctor as [redacted] – not [redacted].[2] She said, "…this has been an ongoing problem."

She said her "liver is drying up" because she can't keep food down or get the nutrients she needs.

The MHP physician witness [redacted] observed that much of what she testified about seems to be new information which should be reported back to her physican with testing and then reconsideration for the supplement.

While this ALJ sympathizes with the Appellant's situation the MHP has inadequate information to make a decision even though they asked for additional information. Absent requested data, 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 [redacted]

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 5-10-12

[1] The Appellant self reported a 12-pound weight loss over the course of a year, but at 5 foot 11 inches is at 230 pounds for body weight.
[2] They are in the same practice. (Resp Ex A, page 13)

***** 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 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.