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) 373-4147

IN THE MATTER OF:

Docket No. 2014-33801 QHP

[redacted] [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.*, and upon the Appellant's request for a hearing.

After due notice, a telephone hearing was held on [redacted] Appellant appeared and testified on her own behalf. [redacted] Manager of Medicaid Operations, appeared and testified on behalf of [redacted], the Respondent Medicaid Health Plan ("MHP").

During the telephone hearing, Appellant indicated that her cellular phone's battery was dying and that she did not have another telephone number for the ALJ to call. Appellant was subsequently disconnected and the hearing concluded. Appellant never contacted the Michigan Administrative Hearing System after her phone's battery died and it is her responsibility to provide a working telephone number for the hearing. Accordingly, the undersigned ALJ finds the record is closed and will decide the case on the evidence that was presented.

ISSUE

Did the MHP properly deny Appellant's request for enteral nutrition (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. Appellant is a [redacted] year-old Medicaid beneficiary enrolled in the Respondent MHP. (Respondent's Exhibit A, page 4).

2. On or about [redacted], the MHP received a prior authorization request submitted on behalf of Appellant for Ensure enteral nutrition from Appellant's healthcare provider. (Respondent's Exhibit B, page 4),

3. Along with that prior authorization request, Appellant's healthcare provider submitted prescriptions for Ensure and medical records. (Respondent's Exhibit B, pages 1-43).

4. The prescriptions, written by [redacted] were dated [redacted] and [redacted]. (Respondent's Exhibit B, pages 2-3).

5. The medical records contained a report from [redacted] regarding a [redacted] office visit and indicated that Appellant weighs [redacted] lbs. and had lost [redacted] pounds over the last year. That visit was a preoperative consultation regarding a resection rectopexy. (Respondent's Exhibit B, pages 10, 20).

6. The medical records also contained a letter from [redacted] to [redacted] dated [redacted] in which he indicated that Appellant has a long history of diarrhea with fecal incontinence; her history is complicated by her schizoaffective disorder and borderline personality disorder; and she has had a weight loss of [redacted] pounds. (Respondent's Exhibit B, page 23).

7. In that letter, [redacted] recommended small, frequent meals for Appellant while also stating that he believed Appellant's schizoaffective disorder and borderline personality disorder are likely responsible for a large portion of her symptom complex. (Respondent's Exhibit B, page 24).

8. The medical records further contained a report from [redacted] regarding a [redacted] office visit and indicated that Appellant weighs [redacted] lbs. and has been diagnosed with rectal bleeding, hyperlipidemia, chronic pain, chronic diarrhea, schizoaffective disorder, and borderline personality disorder, among other conditions. (Respondent's Exhibit B, pages 6-7).

9. Another report of [redacted], dated [redacted], provided that Appellant can only eat tiny meals and that her weight has flucuated from [redacted] lbs. on [redacted] to [redacted] lbs. on [redacted] and [redacted] pounds on [redacted]. (Respondent's Exhibit B, page 28).

10. Regarding the weight loss, [redacted] wrote that there was no diagnosis, but that he suspected that a significant portion of her weight loss and chronic pain is due to psychiatric comorbidities. (Respondent's Exhibit B, page 29).

11. [redacted] also recommended counseling for Appellant. (Respondent's Exhibit B, page 29).

12. On [redacted], the MHP sent Appellant written notice that the prior authorization request for Ensure was denied. (Respondent's Exhibit C, pages 1-2).

13. Specifically, the denial notice stated:

> Information reviewed by us shows that you do not meet the criteria below. Therefore, we are unable to approve the requested Ensure oral supplementation.
>
> This decision is based on medical director review of information submitted by your doctor and the Michigan Department of Community Health (MDCH) Medicaid Provider Manual, Medical Supplier Chapter, Section 2.13.A. Enteral Nutrition (Administrated Orally), which states: Enteral nutrition (administered orally) may be covered for beneficiaries age 21 and over when the following is met: The nutritional composition of the formula represents an integral part of treatment for the specified diagnosis/medical condition and the beneficiary has experienced significant weight loss.
>
> Documentation must be less than 30 days old and include
> a. Amount of calories needed per day.
> b. Current height and weight, as well as change over time.
> c. Specific prescription identifying levels of individual nutrient(s) that is required in increased or restricted amounts.
> d. List of economic alternatives that have been tried.
>
> *Respondent's Exhibit C, page 1*

14. On [redacted] the Michigan Administrative Hearing System (MAHS) received the request for hearing filed by Appellant in this matter. (Petitioner's Exhibit 1, pages 1-4; Respondent's Exhibit A, pages 1-4).

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.

In 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 MHPs and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to its contract with the Department:

> The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.)
>
> MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

MPM, January 1, 2014 version
Medicaid Health Plan Chapter, page 1
(Underline added by ALJ)

The MDCH-MHP contract provisions likewise provide that the MHP may limit services to those that are medically necessary pursuant to its own prior authorization requirements:

> E. Services
>
> (1) Covered Services
>
> 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 but may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an enrollee. In general, the Contractor is responsible for covered services related to the following:
>
> - The prevention, diagnosis, and treatment of health impairments
> - The ability to achieve age-appropriate growth and development
> - The ability to attain, maintain, or regain functional capacity
>
> 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.
>
> * * *
>
> AA. Utilization Management
>
> (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 . . .

Contract No. 071B0200017, Print Version 1/23/2013
Article 1.020 Scope of [Services], pages 22-23, 55
(Underline added by ALJ)

Here, the MHP has developed guidelines with respect to enteral nutrition. (Respondent's Exhibit D, pages 1-10) and, with respect to Medicaid beneficiaries, those guidelines state in part:

E. The following applies to Medicaid and MIChild members only:

1. Enteral nutritional therapy supplies, equipment, accessories and solution are a covered benefit and must be preauthorized by the Health Management Department and obtained from a Priority Health participating pharmacy, contracted DME provider or enteral provider. Most of the

criteria in Section I of this policy are applicable. Exceptions are listed below.

2. 100% hydrolyzed amino acids formulas (including Neocate®) are available through the Women, Infants & Children (WIC) program for children under 5. Priority Health will only prior authorize elemental 100% hydrolyzed amino acids infant formula with written documentation from the member's local health department that it is not available through WIC and medical criteria in Section II above are met.

3. Enteral nutrition administered through a tube follows the commercial guidelines above.

4. Enteral nutrition administered orally (not by tube) may be covered for members. Prior authorization is required and it must be ordered by a Gastroenterologist and/or Developmental Pediatrician (for members under the age of 21). The following guidelines must all be met:

* * *

b. <u>For members age 21 and over:</u>

• The member must have a medical condition that requires the unique composition of the formulae nutrients that the member 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 member has experienced significant weight loss of 10% or greater of their body weight.

• Mechanical or physiological conditions precluding normal dietary intake are taken into consideration for coverage as well as temporary medical complications necessitating a short-term (less than two months) use of the formula. However, coverage to accommodate psychological or behavioral conditions, food preferences, allergies, loss of appetite, or non-compliance with a specialized diet would not be a consideration.

Respondent's Exhibit D, pages 5-6

Priority Health, Medical Policy 91278-R11, pages 2-3 of 7

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

> **2.13 ENTERAL NUTRITION**
>
> Enteral nutrition is nutrition administered by tube or orally into the gastrointestinal tract. Enteral nutrition is classified into categories that possess similar characteristics. Categories for enteral nutrition are listed by HCPCS codes on the MDCH Medical Supplier/DME/Prosthetics and Orthotics Database on the MDCH website.
>
> * * *
>
> **2.13.A. 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 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.

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.

MPM, January 1, 2014 version
Medical Supplier Chapter, pages 32-33

Here, as discussed above, the MHP denied the prior authorization request for enteral nutrition (Ensure) on that basis that the information submitted did not meet the criteria to approve the request. In particular, the MHP's witness noted that the prior authorization request and accompanying documents fail to provide that Appellant has a medical condition that requires the unique composition of the formulae nutrients that the member is unable to obtain from food and, instead, suggested that Appellant's weight loss was the result of her schizoaffective disorder and borderline personality disorder.

In response, Appellant testified that her doctors are wrong to suggest that her schizoaffective disorder and borderline personality disorder are in any way related to her weight loss or inability to consume food. She also testified that she has number of medical conditions, such as gastritis, that are the cause of her issues and she has lost of [redacted] lbs.

Appellant bears the burden of proving by a preponderance of the evidence that the MHP erred in deciding to deny her request. Moreover, this Administrative Law Judge is limited to reviewing the MHP's decision in light of the information it had at the time it made that decision.

In this case, given the information available at the time the MHP made the disputed decision, the undersigned Administrative Law Judge finds that Appellant has failed to meet her burden of proving that the MHP erred and the decision to deny the prior authorization request must therefore be affirmed.

The MPM identifies specific criteria that must be met prior to any approval of enteral nutrition, including the initial requirement that the nutritional composition of the formula represents an integral part of treatment for the specified diagnosis/medical condition. In this case, however, the prescriptions and prior request form are silent as to the basis for the request. Similarly, the attached medical records fail to identify any specified diagnosis/medical condition being treated and the recommendations of the doctors made during the course of treatment only reflect a treatment plan of eating small, frequent meals. Moreover, to the extent Appellant's weight loss is the result of her schizoaffective disorder or borderline personality disorder, as suggested by her doctors, the request would be non-covered under the MHP's specific policy. Appellant may disagree with the judgment of her doctors, but their opinions and submitted document was justifiably relied by the MHP in making its decisions.

In addition to failing to demonstrate that the formula represents an integral part of treatment for the specified diagnosis/medical condition, the submitted documentation, most of which is outside of the [redacted] day period identified in the MPM, also fails to provide other information required by the MPM. For example, there is no list of economic alternatives that have been tried or a clear showing that Appellant has experienced significant weight loss. Appellant has lost a significant amount of weight in the last [redacted] months, but she also gained a significant amount of weight in the [redacted] months prior to that period and the documentation does not clarify the issue.

Overall, the basis for the prior authorization request is unclear and documentation submitted fails to justify approval. To the extent Appellant has additional or updated information to regarding her medical conditions or the treatment of that conditions, she is free to have her doctor resubmit the request for enteral nutrition, along all the relevant documents and information. With respect to the decision at issue in this case, however, the MHP's actions must be affirmed given the available information.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.

Steven Kibit

Steven Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

cc: [redacted]

***** 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.