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Date Mailed: June 7, 2023
MOAHR Docket No.: 23-002435
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200, *et seq.,* and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on May 31, 2023. Petitioner appeared and testified on her own behalf. John Lambert; Appeals Review Officer, represented the Respondent Department of Health and Human Services (DHHS or Department). Rachel Long; Nurse Reviewer, testified as a witness for the Department.

During the telephone hearing, the Department submitted an evidence packet that was admitted into the record as Exhibit A, pages 1-27. No other proposed exhibits were submitted.

ISSUE

Did the Department properly deny Petitioner's prior authorization request for enteral formula?

FINDINGS OF FACT

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

1. Petitioner is an enrolled Medicaid beneficiary. (Exhibit A, page 11).

2. On April 17, 2023, the Department, through its contracted agent iMPROve Health, received a telephone call from Petitioner's medical provider's office requesting enteral formula for Petitioner. (Testimony of Nurse Reviewer).

3. During that call, the representative of the medical provider reported that Petitioner's weight was [redacted] lbs., and that it had been stable for a year. (Exhibit A, page 8; Testimony of Nurse Reviewer).

4. Petitioner's Body Mass Index (BMI) was calculated at [redacted] (Exhibit A, page 8; Testimony of Nurse Reviewer).

5. Prior to requesting enteral formula, nothing else had been tried to address any issues with Petitioner's weight. (Testimony of Petitioner; Testimony of Nurse Reviewer).

6. On April 17, 2023, the Department sent Petitioner written notice that the request for enteral formula had been denied. (Exhibit A, pages 11-12).

7. With respect to the reason for the denial, the notice stated:

> The policy this denial is based on is Section 1.6 and 2.13.A of the Medical Supplier chapter of the Medicaid Provider Manual, which indicates:
>
> The medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity or the type and quantity of items ordered and for the frequency of use or replacement.
>
> 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; or
> - The nutritional composition of the formula represents an integral part of treatment of the specified diagnosis/medical condition; or
> - The beneficiary has experienced significant weight loss.
>
> 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 ration.)

- Specific prescription identifying level of individual nutrient(s) that is required in increased or restrictive amounts.

- List of economic alternatives that have been tried.

Exhibit A, pages 11-12

8. On May 1, 2023, the Michigan Office of Administrative Hearings and Rules (MOAHR) received the request for hearing filed in this matter regarding the Department's decision. (Exhibit A, pages 19-21).

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 statutes, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Medicaid covered benefits are addressed for the practitioners and beneficiaries in the Medicaid Provider Manual (MPM) and, with respect to the equipment at issue in this case, the applicable version of the MPM states in part:

1.6 MEDICAL NECESSITY

Medicaid covers medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for beneficiaries of all ages. DMEPOS are covered if they are the least costly alternative that meets the beneficiary's medical/functional need and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter.

The medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement. The information should include the beneficiary's diagnosis, medical condition, and other pertinent information including, but not limited to, duration of the condition, clinical course, prognosis, nature and extent of functional limitations, other therapeutic

interventions and results, and past experience with related items. Neither a physician, clinical nurse specialist (CNS), nurse practitioner (NP) or physician assistant (PA) order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating/ordering physician, CNS NP or PA. Information in the medical record must support the item's medical necessity and substantiate that the medical device needed is the most appropriate economic alternative that meets MDHHS standards of coverage.

Medical equipment may be determined to be medically necessary when all of the following apply:

- The service/device meets applicable federal and state laws, rules, regulations, and MDHHS promulgated policies.

- It is medically appropriate and necessary to treat a specific medical diagnosis, medical condition, or functional need, and is an integral part of the nursing facility daily plan of care or is required for the community residential setting.

- The safety and effectiveness of the product for age-appropriate treatment has been substantiated by current evidence-based national, state and peer-review medical guidelines.

- The function of the service/device:

  - meets accepted medical standards, practices and guidelines related to:

    - type,

    - frequency, and

    - duration of treatment; and

  - is within scope of current medical practice.

- It is inappropriate to use a nonmedical item.

- It is the most cost effective treatment available.

- The service/device is ordered by the treating physician, NP or PA (for CSHCS beneficiaries, the order must be from the pediatric subspecialist) and clinical documentation from the medical record supports the medical necessity for the request (as described above) and substantiates the practitioner's order.

- The service/device meets the standards of coverage published by MDHHS.

- It meets the definition of Durable Medical Equipment (DME) as defined in the Program Overview section of this chapter.

- Its use meets FDA and manufacturer indications.

MDHHS does not cover the service when Medicare determines that the service is not medically necessary.

Medicaid will not authorize coverage of items because the item(s) is the most recent advancement in technology when the beneficiary's current equipment can meet the beneficiary's basic medical/functional needs.

Medicaid does not cover equipment and supplies that are considered investigational, experimental or have unproven medical indications for treatment.

Refer to the Prior Authorization subsection of this chapter for medical need of an item beyond the MDHHS Standards of Coverage.

NOTE: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative services. Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information.

The Healthy Michigan Plan (HMP) covers habilitative services for all ages. Refer to the Healthy Michigan Plan Chapter for additional information.

* * *

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 MDHHS Medical Supplier/DME/Prosthetics and Orthotics Fee Schedule on the MDHHS website. For the appropriate HCPCS code, products are listed on the enteral nutrition product classification list on the website for the Medicare Pricing, Data Analysis and Coding (PDAC) contractor. If the formula is not listed in the covered HCPCS codes, the provider must contact the PDAC contractor for a coding determination. (Refer to the Directory Appendix for website and contact information.)

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; or ▪ 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; or ▪ 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 Healthcare Common Procedure Coding System (HCPCS) code B4162, the beneficiary must have a specified inherited disease of metabolism identified by the International Classification of Diseases (ICD). 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; or ▪ The nutritional composition of the formula represents an integral part of treatment of the specified diagnosis/medical condition; or ▪ The beneficiary has experienced significant weight loss. For Healthcare Common Procedure Coding System (HCPCS) code B4157, the beneficiary must have a specified inherited disease of metabolism identified by the International Classification of Diseases (ICD).
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. For continued use beyond 3-6 months, the CSHCS Program requires a report from a nutritionist or appropriate pediatric subspecialist.

MPM, April 1, 2023, version
Medical Supplier Chapter
Pages 9-10, 48-49

Here, as discussed above, Respondent denied Petitioner's request for enteral formula pursuant to the above policies.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that the Department erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Department's decision in light of the information available at the time the decision was made.

Given the record and applicable policies in this case, Petitioner has failed to meet that burden of proof and the Department's decision must be affirmed.

At the time of the request in this case, it is undisputed that Petitioner did not meet the applicable standards of coverage given that her weight had been stable at [redacted] lbs. for approximately a year, with Petitioner's BMI in the healthy weight category, and the fact that no more economic alternatives had been tried to address any issues with weight that did exist. Moreover, while Petitioner testified that she has lost [redacted] lbs. in the approximately two months that have passed since the request was made, the undersigned Administrative Law Judge is limited to reviewing the Department's decision in light of the information available at the time the decision was made.

To the extent Petitioner has additional or updated information to provide regarding her need for enteral formula, then she and her provider can always submit a new request in the future along with that information. With respect to the decision at issue in this case however, the Department's decision must be affirmed given the available information and applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly denied Petitioner's prior authorization request.

IT IS THEREFORE ORDERED that:

The Department's decision is **AFFIRMED.**

Steven Kibit

SK/sj

Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioner may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties and/or attorneys, to their last-known addresses in the manner specified below, this 7th day of June 2023.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

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