STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: August 19, 2016
[redacted]
AGENCY: MAP
FH #: 7364900L

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on October 26, 2016, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Care Plan

Nureet Arzi, Managed Care Representative
Alisha Jacobs, Managed Care Representative

ISSUE

Was the determination by Centers Plan to deny the prior approval request for Ensure nutritional supplementation for the Appellant correct?

FACT FINDING

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 82, is enrolled in a Medicaid managed care plan operated by Centers Plan for Healthy Living ("Centers Plan").

2. By notice dated August 15, 2016, Centers Plan denied the prior approval request for Ensure nutritional supplementation as not medically necessary.

3. On August 19, 2016, the Appellant requested this fair hearing.

APPLICABLE LAW

Section 365-a of the Social Services Law provides in part:

> "Medical Assistance" shall mean payment of part or all of the cost of care, services and supplies which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with his capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title, and the regulations...

Section 364-j (1)(c) of the Social Services Law defines "Managed Care Program" as a program in a social services district in which Medicaid recipients enroll on a voluntary or mandatory basis to receive Medicaid services, including case management, directly or indirectly (including by referral) from a managed care provider ("Medicaid Managed Care Health Plan"), or, if applicable, from a mental health special needs plan or a comprehensive HIV special needs plan.

Pursuant to Regulations at 18 NYCRR 513.0, where prior approval of medical, dental and remedial care, services or supplies is required under the MA program, such prior approval will be granted when the medical, dental and remedial care, services or supplies are shown to be medically necessary to prevent, diagnose, correct or cure a condition of the recipient which: (1) causes acute suffering; (2) endangers life; (3) results in illness or infirmity; (4) interferes with the capacity for normal activity; or (5) threatens to cause a significant handicap. Pursuant to 18 NYCRR 513.6, the determination to grant, modify or deny a request initially must be made by qualified Department of Health professional staff exercising professional judgment based upon objective criteria and the written guidelines of the Department of Health and regulations, and commonly accepted medical practice.

Regulations at 18 NYCRR 505.5 regarding durable medical equipment; medical/surgical supplies; orthotic and prosthetic appliances; and orthopedic footwear advise in part:

(g) Benefit limitations. The department shall establish defined benefit limits for certain Medicaid services as part of its Medicaid State Plan. The department shall not allow exceptions to defined benefit limitations. The department has established defined benefit limits on the following services:
(3) Enteral nutritional formulas are limited to coverage for:
(i) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube;
(ii) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means;

(iii) children under age 21 when caloric and dietary nutrients from food cannot be absorbed or metabolized; and
(iv) persons with a diagnosis of HIV infection, AIDS, or HIV-related illness, or other disease or condition, who are oral-fed and who:
(a) require supplemental nutrition, demonstrate documented compliance with an appropriate medical and nutritional plan of care, and have a body mass index under 18.5 as defined by the Centers for Disease Control, up to 1,000 calories per day; or
(b) require supplemental nutrition, demonstrate documented compliance with an appropriate medical and nutritional plan of care, and have a body mass index under 22 as defined by the Centers for Disease Control and a documented, unintentional weight loss of 5 percent or more within the previous 6 month period, up to 1,000 calories per day; or
(c) require total nutritional support, have a permanent structural limitation that prevents the chewing of food, and the placement of a feeding tube is medically contraindicated.

The New York State Medicaid Program Information for All Providers General Policy defines prior approval as the process of evaluating the aspects of a plan of care which may be for a single service or an ongoing series of services in order to determine the medical necessity and appropriateness of the care requested.

The New York State Medicaid Program Durable Medical Equipment, Orthotics, Prosthetics and Supplies Procedure Codes Manual provides:

ENTERAL NUTRITIONAL FORMULA
Benefit Coverage Criteria is limited to:
 Beneficiaries who are fed via nasogastric, gastrostomy or jejunostomy tube.
 Beneficiaries with inborn metabolic disorders.
 Children up to 21 years of age, who require liquid oral nutritional therapy when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized.
 Adults with a diagnosis of HIV infection, AIDS, or HIV-related illness, or other disease or condition, who are oral-fed, and who;
 require supplemental nutrition, demonstrate documented compliance with an appropriate medical and nutritional plan of care, and have a body mass index (BMI) under 18.5 as defined by the Centers for Disease Control, up to 1,000 calories per day; or
 require supplemental nutrition, demonstrate documented compliance with an appropriate medical and nutritional plan of care, have a body mass index (BMI) under 22 as defined by the Centers for Disease Control, and a documented, unintentional weight loss of 5 percent or more within the previous 6 month period, up to 1,000 calories per day; or
 require total oral nutritional support, have a permanent structural limitation that prevents the chewing of food, and placement of a feeding tube is medically contraindicated.

Documentation Requirements:
 The therapy must be an integral component of a documented medical treatment plan and ordered in writing by an authorized practitioner. It is the responsibility of the practitioner to

maintain documentation in the beneficiary's record regarding the medical necessity for enteral nutritional formula.
 The physician or other appropriate health care practitioner has documented the beneficiary's nutritional depletion.
 Medical necessity for enteral nutritional formula must be substantiated by documented physical findings and/or laboratory data (e.g., changes in skin or bones, significant loss of lean body mass, abnormal serum/urine albumin, protein, iron or calcium levels, or physiological disorders resulting from surgery, etc.)
 Documentation for beneficiaries who qualify for enteral formula benefit must include an established diagnostic condition and the pathological process causing malnutrition and one or more of the following items:
(a)Clinical findings related to the malnutrition such as a recent involuntary weight loss or a child with no weight or height increase for six months.
(b)Laboratory evidence of low serum proteins (i.e., serum albumin less than 3 gms/dl; anemia or leukopenia less than 1200/cmm);
(c)Failure to increase body weight with usual solid or oral liquid food intake.
Additional Information:
●Non-standard infant formulas are reimbursable by Medicaid under the appropriate enteral therapy code.
●The calculation for pricing enteral formula is as follows: Number of calories per can divided by 100 equals the number of caloric units per can.
●Enteral formula requires voice interactive prior authorization, as indicated by the "*" next to the code description. The prescriber must write the prior authorization number on the fiscal order and the dispenser completes the authorization process by calling (866) 211-1736. For requests that exceed 2,000 calories per day for qualifying beneficiaries, a prior approval request may be submitted with medical justification.
●The New York State Medicaid Program does not cover enteral nutritional therapy as a convenient food substitute.
●Standard milk-based infant formulas are not reimbursable by Medicaid.

DISCUSSION

The Appellant, age 82, is enrolled in a Medicaid managed care plan operated by Centers Plan for Healthy Living ("Centers Plan"). By notice dated August 15, 2016, Centers Plan denied the prior approval request for Ensure nutritional supplementation as not medically necessary.

The Appellant's son testified that the Appellant has Oral Cancer and had her upper and lower gums removed. The Appellant's son further testified that the Appellant cannot chew or eat and needs the Ensure for sustenance. The Managed Care Representative testified that the Appellant's most recent weight measured on February 1, 2016 was 152 pounds and her Body Mass Index (BMI) was 29.7 (normal range 18.5024.9). The Appellant's weight was 160 pounds and her BMI was 31.2 on May 24, 2016.

However, the record has been reviewed, and there is no evidence in the record as to what, if any, documentation was reviewed by Centers Plan to establish their denial. The initial request for Ensure was not provided nor any documents to establish the Appellant's weight. Further, the Appellant's son credibly testified that the Appellant visited her doctor on September 27, 2016 and weighed 147 pounds. Therefore, based on the lack of information in the record, the determination to deny the request for Ensure nutritional supplementation cannot be sustained.

DECISION AND ORDER

The August 15, 2016 determination by Centers Plan, to deny the prior approval request for Ensure nutritional supplementation for the Appellant, was not correct and is reversed. Centers Plan is directed to:

1. Approve the requested nutritional supplementation for the Appellant, and notify the Appellant and her doctor in writing when it has complied with this directive.

Should Centers Plan need additional information from the Appellant and/ or her provider in order to comply with the above directives, it is directed to notify the Appellant and/ or her provider promptly in writing as to what documentation is needed. If such information is required, the Appellant must provide it to Centers Plan promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, United Health Care Plan of New York, Inc. must comply immediately with the directives set forth above.

DATED: Albany, New York
11/02/2016

NEW YORK STATE DEPARTMENT
OF HEALTH

By

Commissioner's Designee