STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: June 19, 2017
[redacted]
AGENCY: MAP
FH #: 7555292P

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 August 25, 2017, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Alisha Jacobs, Fair Hearing Representative

ISSUE

Was the determination by the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living LLP, to discontinue the Appellant's authorization for Ensure (Enteral), correct?

FINDINGS OF FACT

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 41, has been in receipt of Medicaid benefits, including Personal Care Services ("PCS)", provided through a Managed Long Term Care ("MLTC") health care plan ("the Plan") operated by Centers Plan for Healthy Living LLP.

2. The Appellant had been authorized, prior to switching Plans as well as during the 90-day continuity of care period during which benefits were locked in, to receive Ensure (Enteral) as part of a treatment regimen to stabilize the Appellant's weight because of a number of chronic conditions.

3. By a communication dated April 24, 2017 from the Appellant's physician to the Plan, the Appellant's physician certified the following to the Plan: "the consumer {sic, does not} have an absorption problem, swallowing dysfunction, obstruction or require tube feeding;" "E-D flares may lead to dysphagia;" weight from August, 2016 through April, 2017, ranging from 163lbs to 170lbs, with ensure supplementation; "the adult patient {sic, has not} had a significant unintentional weight {sic, loss};" "the medical record does {sic, not} support attempts to address nutritional needs with alternatives such as dietary changes, instant breakfast drinks, rice cereal, nutritional counseling, etc.;" and "there is {sic, no} objective medical evidence in the medical record to support the need for enteral nutrition (e.g., malnutrition documented by serum protein levels, albumin levels or hemoglobin, changes in skin or bones, physiological disorders resulting from surgery".

4. By notices dated May 4, 2017, the Plan informed the Appellant of its determination to discontinue the Appellant's authorization for Ensure (Enteral) because "Your most recent weight, measured on 4/24/17 was 170 lbs and your Body Mass Index (BMI) was 27.4 (normal range 18.5. Generally, Medicaid guidelines for the use of nutritional supplementation (such as Ensure) is limited to people who are fed via nasogastric, jejunostomy or gastrostomy tube; for the treatment of inborn errors of metabolism; and adults with a diagnosis of HIV infection. AIDS, or HIV-related illness, or other disease or condition, who are orally-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 (BMI) under 135, as defined by the Centers for Disease Control or (b) 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, 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. The clinical information provided shows that your BMI is above the range normally considered for nutritional supplementation."

5. By Notices dated June 12, 2017, the Plan informed the Appellant of its determination to discontinue the Appellant's authorization for Ensure (Enteral) because "Managed Long Term Care (MLTC) coverage for the use of nutritional supplementation such as Ensure is limited to people who are fed via nasogastric, jejunostomy or gastrostomy tube and for the treatment of inborn errors of metabolism."

6. On July 7, 2017, the Appellant requested this fair hearing to contest the Plan's determination.

APPLICABLE LAW

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, SNAP benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

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

2. "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 ...

This paragraph continues, in part, by stating: “Such care, services and supplies shall include the following medical care, services and supplies, together with such medical care, services and supplies provided for in subdivisions three, four and five of this section, and such medical care, services and supplies as are authorized in the regulations of the department:”

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(g) sickroom supplies, eyeglasses, prosthetic appliances and dental prosthetic appliances furnished in accordance with the regulations of the department; provided further that:

(i) the commissioner of health is authorized to implement a preferred diabetic supply program wherein the department of health will receive enhanced rebates from preferred manufacturers of glucometers and test strips, and may subject non-preferred manufacturers' glucometers and test strips to prior authorization under section two hundred seventy-three of the public health law;
(ii) **enteral formula therapy and nutritional supplements are limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding, for treatment of an inborn metabolic disorder, or to address growth and development problems in children, or, subject to standards established by the commissioner, for persons with a diagnosis of HIV infection, AIDS or HIV-related illness or other diseases and conditions**;
(iii) prescription footwear and inserts are limited to coverage only when used as an

integral part of a lower limb orthotic appliance, as part of a diabetic treatment plan, or to address growth and development problems in children;
(iv) compression and support stockings are limited to coverage only for pregnancy or treatment of venous stasis ulcers; and
(v) the commissioner of health is authorized to implement an incontinence supply utilization management program to reduce costs without limiting access through the existing provider network, including but not limited to single or multiple source contracts or, a preferred incontinence supply program wherein the department of health will receive enhanced rebates from preferred manufacturers of incontinence supplies, and may subject non-preferred manufacturers' incontinence supplies to prior approval pursuant to regulations of the department, provided any necessary approvals under federal law have been obtained to receive federal financial participation in the costs of incontinence supplies provided pursuant to this subparagraph;

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 the Medicaid Managed Care Model Contract, Managed Care Plans agree to provide medically necessary services to enrollees. "Medically necessary" is defined in Social Services law as medical, dental, and remedial care, services and supplies which are necessary to prevent, diagnose, and correct or cure conditions in the person that may cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap [see Social Services Law 365-a(2)]. Also, by statute, EPSDT and family planning services are "deemed" medically necessary and therefore are, by definition, covered.

Chapter 10 of the Medicaid Managed Care Model Contract states, in part:

10.1 Contractor Responsibilities

a) Contractor must provide or arrange for the provision of all services set forth in the Benefit Package for MMC Enrollees and FHPlus Enrollees subject to any exclusions or limitations imposed by Federal or State Law during the period of this Agreement. SDOH shall assure that Medicaid services covered under the Medicaid fee-for-service program but not covered in the Benefit Package are available to and accessible by MMC Enrollees.

b) [Applicable to the HIV SNP Program Only]: The Contractor must promote access and ensure referrals to fee-for-service Medicaid benefits through the HIV SNP care and benefit coordination process for Enrollees determined to be in need of such services.

10.2 Compliance with State Medicaid Plan, Applicable Laws and Regulations

a) All services provided under the Benefit Package to MMC Enrollees must comply with all the standards of the State Medicaid Plan established pursuant to Section 363-a of the SSL and hall satisfy all other applicable requirements of the SSL and PHL.

b) Benefit Package Services provided by the Contractor through its FHPlus product shall comply with all applicable requirements of the PHL and SSL.

c) Pursuant to 42 CFR 438.210, the Contractor may establish appropriate limits on a service for utilization control and/or medical necessity. The Contractor must ensure that Covered Services are provided in sufficient amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor will not define medically necessary services in a manner that limits the scope of benefits provided in the SSL, the State Medicaid Plan, State regulations or the Medicaid Provider Manuals.

Medicaid managed care enrollees' access to the Fair Hearing Process is maintained under the Partnership Plan. Medicaid managed care enrollees may access the Fair Hearing Process in accordance with federal and State statutory requirements, and regulations. See e.g., 42 C.F.R 431.200 et.seq. (Subpart E); N.Y. Soc. Serv. L. sections 22, 364-j(9); 18 N.Y.C.R.R. Part 358.

18 NYCRR section 513.5(a) states:

The Department of Health must assist the recipient in obtaining information and documentation in support of his or her request from: providers who have treated the recipient; social services district records; and other sources, including any information in the recipient's case file or medical history, information from public or private social welfare agencies, non-medical sources, other practitioners and observations by Department of Health and social services district personnel.

Subsection (c) of the same Regulation states:

Since the ordering practitioner is the preferred sources of information, the Department of Health must make all reasonable efforts to obtain needed information from the ordering practitioner before evaluating information obtained from other sources or requesting a clinical examination. If the information provided by the ordering practitioner is incomplete, the Department of Health must attempt to secure additional information, interpretations or explanations from the ordering practitioner, the treating practitioner and the potential provider before requesting a clinical examination.

18 NYCRR section 360-10.8 provides, in part (referring, at times, to the “MMCO,” or “Medicaid Managed Care Organization”):

(f) Responsibilities of social services districts and MMCOs

(1) For fair hearings about enrollment, disenrollment, or Medicaid eligibility, a representative of the social services district must appear at the hearing or obtain a waiver of personal appearance, and the district must comply with the other requirements of sections 358-4.2 and 358-4.3 of this Title.

(2) For fair hearings challenging MMCO determinations concerning services or treatment, the social services district may, but is not required to, appear at the fair hearing.

(3) The MMCO must prepare evidence to justify its challenged determinations. Upon request, the MMCO must provide to the enrollee or the enrollee's authorized representative copies of the documents the MMCO will present at the fair hearing. Upon request, the MMCO must also provide the enrollee or the enrollee's authorized representative access to the enrollee's MMCO case file, and provide copies of documents contained in the file. Such copies must be provided at a reasonable time before the date of the hearing. If the request for copies of documents is made less than five business days before the hearing, the social services district and the MMCO must provide the enrollee and the enrollee's authorized representative such copies no later than at the time of the hearing. Such documents must be provided without charge and must be provided to the enrollee and the enrollee's authorized representative by mail within a reasonable time from the date of the request if the enrollee or the enrollee's authorized representative request that such documents be mailed; provided however, if there is insufficient time for such documents to be mailed and received before the scheduled date of the hearing such documents may be presented at the hearing instead of being mailed.

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.

Section I of 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 that 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.

18 NYCRR 505.5 Durable medical equipment; medical/surgical supplies; orthotic and prosthetic appliances; orthopedic footwear.

(a)Definitions

(1) Durable medical equipment means devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a practitioner in the treatment of a specific medical condition and which have all of the following characteristics:

(i) can withstand repeated use for a protracted period of time;
(ii) are primarily and customarily used for medical purposes;
(iii) are generally not useful to a person in the absence of an illness or

injury; and

(iv) are usually not fitted, designed or fashioned for a particular individual's use. Where equipment is intended for use by only one person, it may be either custom-made or customized.

(2) Medical/surgical supplies means items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment, or orthopedic footwear which have been ordered by a practitioner in the treatment of a specific medical condition and which are usually:

(i) consumable;
(ii) nonreusable;
(iii) disposable;
(iv) for a specific rather than incidental purpose; and
(v) generally have no salvageable value.

Effective January 2009, Department policy requires that when an enrollee is eligible for both Medicare and Medicaid benefits (i.e., dually eligible), the provider must bill Medicare first for covered services prior to submitting a claim to Medicaid for coinsurance and deductible. Prior approval from Medicaid is not required when billing Medicare coinsurance and deductible for services otherwise requiring prior approval for Medicaid-only enrollees.

When a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) item is statutorily never covered by Medicare (e.g., bathing equipment) and is covered by Medicaid, a prior approval request may be submitted to Medicaid along with documentation of medical necessity. It is not necessary to submit claims to Medicare before requesting Medicaid prior approval in this situation.

When the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) issues a claim denial because the Medicare beneficiary has received a product within the last five years which has the same or similar therapeutic benefit for the same medical condition, the provider must include documentation of the DME MAC denial with any Medicaid prior approval request. The prior approval request must include any information available to the provider about the item or items that caused the current Medicare claim to be rejected. Based upon this information Medicaid will make an independent determination of current medical necessity and appropriateness with respect to the requested item.

When the DMEMAC issues a claim denial because a requested item is not being used "in the home", the provider must submit documentation of the DME MAC claim rejection with any Medicaid prior approval request. The prior approval request must also contain any information available to the provider about products supplied under Medicare reimbursement for the beneficiary's use in the home. Medicaid will review prior approval requests for non-ADMC powered wheeled mobility bases prior to Medicare claim submission if the base is not to be used in the home.

When the DME MAC issues a claim denial because the physician's order for a Medicare covered item requests quantities that exceed Medicare payment screens, the provider must submit documentation of the denial with any Medicaid prior approval. The provider must then proceed to appeal that denial to the DME MAC and maintain a copy of the DME MAC's determination on the appeal in the provider's records for any Medicaid post-audit purposes. Unlike most services, certain customized or specialized wheeled mobility bases are eligible for a Medicare ADMC review prior to provision of service. When Medicare issues a negative ADMC decision which communicates that the beneficiary does not meet Medicare coverage criteria established for the base equipment, Medicaid will review a prior approval request. The request must include a copy of the ADMC and all the supporting documentation required by and submitted to Medicare*. This process is not to be utilized when the ADMC states that documentation submitted to Medicare was not sufficient for a determination to be made or when Medicare procedure and documentation requirements have not been met or followed. When a particular item is eligible for ADMC, all options and accessories ordered by the physician for that patient, along with the base HCPCS code, are eligible for ADMC. *Refer to the DME MAC Supplier Manual.

Appendix K2 section 10(a) of the Medicaid/FHP managed care model contract advises in part regarding **Prescription and Non-Prescription (OTC) Drugs, Medical Supplies and Enteral Formulas** for Medicaid managed care only: Enrollees are covered for prescription drugs through the Medicaid fee-for-service program through September 30, 2011, except for pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit and self-administered injectable drugs (including those administered by a family member and during a home care visit) not included on the Medicaid outpatient formulary, which are covered by the Contractor. Effective October 1, 2011, medically necessary prescription and non-prescription (OTC) drugs, medical supplies, hearing aid batteries and enteral formula are covered by the Contractor when ordered by a qualified provider.

Appendix K2 section 10(c) of the Medicaid/FHP model contract advises that for Medicaid Managed Care and Family Health Plus, effective October 1, 2011:

i) Prescription drugs may be limited to generic medications when medically acceptable. All drug classes containing drugs used for preventive and therapeutic purposes are covered, as well as family planning and contraceptive medications and devices, if Family Planning is included in the Contractor’s Benefit Package.

ii) Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit are covered by the Contractor. Self-administered injectable drugs (including those administered by a family member) and injectable drugs administered during a home care visit are also covered by the Contractor. The following drugs are covered by Medicaid fee-for-service: 1) hemophilia blood factors, whether furnished or administered as part of a clinic or office visit or administered during a home care visit; and 2) Risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®) and olanzapine (Zyprexa® Relprevv™) when administered to SSI and SSI-related Enrollees in mainstream Medicaid managed care plans.
iii) Coverage of enteral formula is limited to individuals who cannot obtain nutrition

through any other means, and to the following three conditions: 1) Individuals who are fed via nasogastric, gastronomy or jejunostomy tube; 2) Individuals with inborn metabolic disorders; and, 3) Children up to 21 years of age who require liquid oral enteral nutritional formula when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.
iv) Fluoride supplements are covered for children up to age 17.
v) Experimental and investigational drugs are generally excluded, except where included in the course of Contractor-authorized experimental/investigational treatment or ordered under the External Appeal program authorized under Article 49 of the Public Health Law.
vi) The following drugs are not covered:
1. Vitamins except when necessary to treat a diagnosed illness or condition, including pregnancy;
2. Drugs prescribed for cosmetic purposes;
3. Drugs prescribed for anorexia, weight loss or weight gain;
4. Drugs prescribed to promote fertility;
5. Drugs used for the treatment of sexual or erectile dysfunction unless used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the Food and Drug Administration; and
6. Covered outpatient drugs when the manufacturer seeks to require, as a condition of sale, that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
vii) The Contractor may establish a prescription formulary, including a therapeutic category formulary, as long as the formulary includes all categories of drugs as listed on the New York State Medicaid formulary, and as long as the Contractor has in place a brand name and therapeutic category exception process for providers to use when the provider deems medically necessary.

18 NYCRR section 358-4.3 provides, in part, that a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination.

Section 358-5.9 of the Regulations provide in part:

(a) At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services, the appellant must establish that the agency's denial of assistance or benefits was not correct or that the appellant is eligible for a greater amount of assistance or benefits.

DISCUSSION

The record establishes the following relevant facts. The Appellant had been authorized, prior to switching Plans as well as during the 90-day continuity of care period during which benefits were locked in, to receive Ensure (Enteral) as part of a treatment regimen to stabilize the Appellant's weight because of a number of chronic conditions, including Ehlers-Danlos Syndrome (a group of genetic connective tissue disorders with symptoms including flexible joints and stretchy, fragile skin, and abnormal scar formation; a more severe form can cause the walls of blood vessels, intestines or uterus to rupture), hypothyroidism, gastroesophageal reflux disease, gastritis, peptic ulcers, esophagitis, dysphagia (difficulty swallowing) and Grave's disease (abnormal over activity of the thyroid gland affecting metabolism).

By a communication dated April 24, 2017 from the Appellant's physician to the Plan, the Appellant's physician certified the following to the Plan: "the consumer {sic, does not} have an absorption problem, swallowing dysfunction, obstruction or require tube feeding;" "E-D flares may lead to dysphagia;" weight from August, 2016 through April, 2017, ranging from 163lbs to 170lbs, with ensure supplementation; "the adult patient {sic, has not} had a significant unintentional weight {sic, loss};" "the medical record does {sic, not} support attempts to address nutritional needs with alternatives such as dietary changes, instant breakfast drinks, rice cereal, nutritional counseling, etc.;" and "there is {sic, no} objective medical evidence in the medical record to support the need for enteral nutrition (e.g., malnutrition documented by serum protein levels, albumin levels or hemoglobin, changes in skin or bones, physiological disorders resulting from surgery".

By notices dated May 4, 2017, the Plan informed the Appellant of its determination to discontinue the Appellant's authorization for Ensure (Enteral) because "Your most recent weight, measured on 4/24/17 was 170 lbs and your Body Mass Index (BMI) was 27.4 (normal range 18.5. Generally, Medicaid guidelines for the use of nutritional supplementation (such as Ensure) is limited to people who are fed via nasogastric, jejunostomy or gastrostomy tube; for the treatment of inborn errors of metabolism; and adults with a diagnosis of HIV infection. AIDS, or HIV-related illness, or other disease or condition, who are orally-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 (BMI) under 135, as defined by the Centers for Disease Control or (b) 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, 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. The clinical information provided shows that your BMI is above the range normally considered for nutritional supplementation."

By Notices dated June 12, 2017, the Plan informed the Appellant of its determination to discontinue the Appellant's authorization for Ensure (Enteral) because "Managed Long Term Care (MLTC) coverage for the use of nutritional supplementation such as Ensure is limited to

people who are fed via nasogastric, jejunostomy or gastrostomy tube and for the treatment of inborn errors of metabolism."

Appendix K2 section 10(c) of the Medicaid/FHP model contract advises that for Medicaid Managed Care and Family Health Plus, effective October 1, 2011, provides: iii) Coverage of enteral formula is limited to individuals who cannot obtain nutrition through any other means, and to the following three conditions: 1) Individuals who are fed via nasogastric, gastronomy or jejunostomy tube; 2) Individuals with inborn metabolic disorders; and, 3) Children up to 21 years of age who require liquid oral enteral nutritional formula when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.

At the hearing, the Appellant contended that the aides were not following directives as to what to prepare and how to prepare it in order to render the meal consumable by the Appellant. However, the Appellant implicitly admitted to not being tube fed, is not under 21 years of age, and, while suffering from a recently diagnosed genetic disorder, said disorder is characterized in the record as being neuromuscular and not metabolic per se.

It is noted that, while the Appellant has a number of disorders, the record does not establish that any genetic disorders are directly linked to an inability to metabolize food. It is further noted that the physician's response to the Plan's request for a Letter of Medical Necessity undermines the Appellant's medical need for enteral. It is also noted that the physician's letters dated in the Spring, 2017, characterize enteral as a "benefit," rather than a "necessity." It is additionally noted that the Appellant's weight has been stable, albeit with enteral, for over a year. No regimen of liquefied diets, to the extent that solids are not tolerated, had been attempted, with either failure or contraindication clinically documented.

Accordingly, the Plan's determination, supported by the lack of any evidence to the contrary, must be sustained.

DECISION

The determination by the Appellant's Managed Long Term Care Plan, Centers Plan for Healthy Living LLP, to discontinue the Appellant's authorization for Ensure (Enteral) is correct.

DATED: Albany, New York
09/06/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee