STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
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],

Appellant
_____/

Docket No. 2009-30050 QHP
Case No. [redacted]

DECISION AND ORDER

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

After due notice, a hearing was held [redacted]. [redacted] (the Appellant) appeared and testified on her own behalf.

[redacted] represented [redacted], the MHP. [redacted] presented testimony on behalf of the [redacted]. [redacted] was present on behalf of the MHP.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for Topamax?

FINDINGS OF FACT

Based upon the competent, material and substantial evidence presented, I find, as material fact:

1. The Appellant is a Medicaid beneficiary, who is currently enrolled with [redacted], a Medicaid health plan.

2. The Appellant is diagnosed with epilepsy. Her physician has prescribed Topamax for the purpose of controlling her seizures.

3. The MHP has sought clinician documentation that the Appellant has participated in a trial of the generic equivalent of Topamax.

4. The Appellant has not participated in a trial of the generic equivalent for Topamax. There is no documentation the generic equivalent is not effective for the Appellant.

5. The MHP denied the request for prior authorization of Topamax based upon lack of documentation of a medical necessity for the brand name drug rather than its generic equivalent.

6. On [redacted], the Appellant filed a Request for Hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

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 Medicaid Health Plans.

The Respondent is one of those Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors 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 1-Z.
>
> *Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, September 30, 2004.*

> The major components of the Contractor's utilization management plan 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 Contractor must establish and use a written prior approval policy and procedure for utilization management 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 utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
>
> *Article II-P, Utilization Management, Contract, September 30, 2004*

[redacted] Prior Authorization process requires clinical documentation that the generic equivalent for a drug be used whenever efficiacious. Documentation must establish lack of effectiveness by a generic before a brand name can be given prior authorization. In this case it is an uncontested material fact the Appellant did not attempt a trial of the generic equivalent of Topamax before requesting prior authorization for the brand name prescription. At hearing she testified her mother had tried it and it made her feel "weird," therefore she was not going to try it. She also testified she had tried other generic drugs in the past but it had been a couple of years since she tried a generic medication. She asserts she cannot because of her epilepsy.

The material facts are not in dispute. The Appellant has not attempted a clinical trial of the generic equivalent for Topamax, thus no documentation exists that it is less efficacious than the brand name. The prior authorization requirements in place by [redacted] are consistent with those set forth in Medicaid Policy. The MHP is within its rights to use the prior authorization process that is in place. The Appellant has not followed it, thus she was properly denied the brand name drug in this instance.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I find that the MHP appropriately denied Appellant's prior authorization request for Topamax.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 9/9/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.