STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Appellant
________________________/

Docket No. 2009-5554 PHR
Case No.
Load No.

DECISION AND ORDER

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

After due notice, a hearing was held on (Appellant) appeared and testified on her own behalf. , Appellant's spouse, appeared and testified as a witness for Appellant. , represented the Department's agent, .

ISSUE

Did the Department properly deny Appellant's request for prior authorization for Optisource?

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 year-old female Medicaid beneficiary.

2. On , staff received a prior authorization request from Appellant's medical doctor who requested coverage of Optisource for the treatment of Appellant's malabsorption status post gastric bypass surgery in , and anemia. (Exhibit 1, p.3)

3. In the prior authorization request, Appellant's doctor noted that Appellant has tried other multivitamins, but has experienced nausea and vomiting; and Appellant will need a multivitamin with iron for life. (Exhibit 1, p. 4)

4. The prior authorization request received from Appellant's doctor was reviewed by the Department/ and referred to the Michigan Department of Community Health physician reviewer because it could not be approved.

5. The Department physician denied the prior authorization request after reviewing it.

6. On the Department mailed an Adequate Action Notice to the Appellant to inform her that the request for Optisource was denied for the reason that "this action does not meet criteria." (Exhibit 1, p. 5)

7. On the Department received Appellant's hearing request, protesting the denial.

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.

Social Security Act § 1927(d), [*42 USC 1396r-8(d)*]

(d) LIMITATIONS ON COVERAGE OF DRUGS --
(1) PERMISSIBLE RESTRICTIONS –

(A) A state may subject to prior authorization any covered outpatient drug. Any such prior authorization program shall comply with the requirements of paragraph (5).

(B) **A state may exclude or otherwise restrict coverage of a covered outpatient drug if** –

(i) the prescribed use is not for a medically accepted indication (as defined in subsection (k)(6);
(ii) the drug is contained in the list referred to in paragraph (2);

(iii) the drug is subject to such restriction pursuant to an agreement between a manufacturer and a State authorized by the Secretary under subsection (a)(1) or in effect pursuant to subsection (a)(4); or

(iv) the State has excluded coverage of the drug from its formulary in accordance with paragraph 4.

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A prior authorization program established by a State under paragraph (5) is not a formulary subject to the requirements of this paragraph.

(5) REQUIREMENTS OF PRIOR AUTHORIZATION PROGRAMS - A State plan under this title may require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, with respect to drugs dispensed on or after July 1, 1991, the approval of the drug before its dispensing for any medically accepted indication (as defined in subsection (k)(6)) only if the system providing for such approval –

(A) Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and
(B) Except with respect to the drugs referred to in paragraph (2) provides for the dispensing of at least 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

(6) OTHER PERMISSIBLE RESTRICTIONS - A State may impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills, if such limitations are necessary to discourage waste, and may address instances or fraud or abuse by individuals in any manner authorized under this Act.

Furthermore, the Medicaid Provider Manual (MPM) sets forth significant criteria for documentation of purported off-label uses and prior authorization requests:

DOCUMENTATION REQUIREMENTS

For all requests for PA, the following documentation is required:

- Pharmacy name and phone number;
- Beneficiary diagnosis and medical reasons why another covered drug cannot be used;
- Drug name, strength, and form;
- Other pharmaceutical products prescribed;
- Results of therapeutic alternative medications tried; and
- MedWatch Form or other clinical information may be required.

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PRIOR AUTHORIZATION DENIALS

PA denials are conveyed to the requester. PA is denied if:

- The medical necessity is not established.
- Alternative medications are not ruled out.
- Evidence-based research and compendia do not support it.
- It is contraindicated, inappropriate standard of care.
- It does not fall within MDCH clinical review criteria.
- Documentation required was not provided.

MPM, Pharmacy §§8.4, 8.6, pages 15 and 16, January 1, 2008.

In the case, Appellant's medical doctor sought prior authorization for the coverage of Optisource to treat Appellant's malabsorption status post gastric bypass surgery and anemia. Appellant testified that she has numerous medical problems and is unable to eat and digest a lot of food. She testified that other vitamins are too strong and cause her to throw up. Appellant does not understand why Medicaid covered her surgery, but will not cover the product that she needs to treat her malabsorption status post gastric bypass surgery and anemia.

The Department's witness from [redacted] provided documentation to establish that Optisource is not a Medicaid-covered benefit because it is considered a non-rebatable drug that is not covered, but would still qualify for MDCH physician review. The Department's witness said that non-rebatable means that Medicaid will not get any reimbursement from the federal government if the drug is paid for by Medicaid. Appellant's prior authorization request was sent to the MDCH physician for review. The MDCH physician determined that Appellant does not meet the criteria for Optisource. The Medicaid Provider Manual, Pharmacy section, effective July 1, 2007, states clearly that vitamin/mineral combinations not for prenatal care, end stage renal disease or pediatric fluoride supplementation is not covered as a benefit. Accordingly, the denial of

Appellant's request for Optisource must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied Appellant's request for prior authorization of Optisource.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Marya A. Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: 3/5/2009

***** 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 receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.