STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2010-36662 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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared as the Appellant's representative. [redacted] appeared and testified.

[redacted] was represented by [redacted], and [redacted], appeared as witnesses for [redacted]. [redacted] is a Department of Community Health contracted Medicaid Health Plan (hereinafter MHP).

ISSUE

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

FINDINGS OF FACT

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

1. The Appellant is a Medicaid beneficiary who is currently enrolled in [redacted], a Medicaid Health Plan (MHP).

2. The Appellant suffers from moderate lumbar stenosis, chronic pain, obstructive sleep apnea, fibromyalgia, celiac disease, COPD, low back pain with Grade I spondylolisthesis, and cerebral microvascular disease. (Exhibit 1, pages 9 and 11-12, Exhibit 2)

3. On [redacted], the MHP received a prior authorization request for OxyContin 80 mg, from the Appellant's doctor, [redacted]. (Exhibit 1, page 9)

4. On [redacted], the MHP received additional documentation from the Appellant's doctor's office. (Exhibit 1, pages 10-12)

5. On [redacted], the MHP sent the Appellant a Notification of Denied Service stating that the request for OxyContin was not authorized because the information submitted did not show the coverage criteria were met, including a trial and failure of long-acting opioid formulary medication morphine sulfate (MS Contin). (Exhibit 1, pages 13-15)

6. The Appellant appealed the denial on [redacted]. (Exhibit 1, page 7)

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.*

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The RN Manager of Clinical Services explained that for a narcotic such as OxyContin, the prior approval is required. In order to achieve prior approval, it was further explained that a step therapy program must have been completed, which includes a therapeutic trial and failure of MS Contin prior to the request for OxyContin. (Exhibit 1, page 20) The RN Manager of Clinical Services

testified that the information submitted with the request for OxyContin did not show the step therapy requirements documenting a trial and failure of MS Contin were met in the Appellant's case. She further testified that the MHP checked with the Appellant's doctor, who indicated there was no documentation supporting a trial of MS Contin.

The Appellant testified that she tried MS Contin in [redacted] but went into overdose because her system loads this medication rather than passing it. The Appellant questioned which doctor the MHP requested documentation from because as she stated there has been multiple prior authorization requests submitted, with at least one with a higher dosage prescribed and from another provider.

The MHP testified that they have not received other prior authorization requests for OxyContin for the Appellant. The record was left open for 10 days for the Appellant to provide evidence of the other prior authorization requests. The only evidence received by the time this Hearing Decision was issued was a [redacted], office note indicating the Appellant's neurologist intended to submit a prior authorization request for OxyContin CR. (Exhibit 2) No dosage information was listed nor was there evidence the request was actually submitted to the MHP. However, as the MHP indicated at the hearing, a new prior authorization request with supporting documentation can always be submitted to the MHP.

The MHP can only make a determination using the information available at the time of the request. The MHP provided sufficient evidence that its formulary and medication prior approval process is consistent with Medicaid policy and allowable under the DCH-MHP contract provisions. The MHP demonstrated that based on the information it had at the time the denial decision was made, the Appellant did not meet criteria for approval of OxyContin. As such, the MHP properly denied prior approval of OxyContin.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

_____

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

[redacted]
Docket No. 2010-36662 QHP
Decision and Order

cc: [redacted]

Date Mailed: 8/17/2010

***** 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.