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

Docket No. 2010-55017 PHR
[redacted], Case No. [redacted]

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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 [redacted]. [redacted] was represented by her mother, [redacted].

[redacted], represented the Department of Community Health.

ISSUE

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

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 an [redacted] Medicaid recipient.

2. On [redacted], the Department received a prior authorization request for the medication Adderall from the Appellant's general practitioner. (Exhibit A, page 4)

3. The Appellant was diagnosed with ADHD as a child and received therapeutic treatment in the form of medication.

4. The Appellant has been prescribed Adderall in the past, however, did have a brief interruption of therapy in [redacted].

5. The Department does not have records of paid claims through Medicaid for the treatment the Appellant has been receiving past [redacted].

6. The Appellant asserts she did have medication prescribed through [redacted], although her doctor had prescribed a different medication for a short period of time. It is uncontested she did not have medication prescribed after [redacted] until [redacted]. (testimony from the Appellant's mother)

7. Michigan Medicaid program guidelines for a person that was treated as a child for ADD/ADHD and now presents for an extension of that treatment state that MDCH review is required unless the diagnosis or evaluation has been made by a psychiatrist or a CHP professional after turning 18 years old. If MDCH review is necessary, information is needed regarding when the initial diagnosis was made, when the ADHD was last treated, and if the patient is still in school, is working, or what the social implication of the diagnosis are. Michigan Department of Community Health (MDCH) PDL & MAP Criteria, Attention Deficit/Hyperactivity Disorder (ADD/ADHD) Agents, June 1, 2010, page 55. (Exhibit A, page 9)

8. The request was forwarded to a Department physician reviewer. The Department reviewer denied the request.

9. On [redacted], an Adequate Action Notice of denial was sent to the Appellant. (Exhibit A, page 7)

10. The Appellant requested a formal, administrative hearing [redacted]. (Exhibit A, page 2)

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.

The Social Security Act § 1927(d), *42 USC 1396r-8(d)*, provides as follows:

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).

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.

(2) LIST OF DRUGS SUBJECT TO RESTRICTION –The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:

(A) Agents when used for anorexia, weight loss, or weight gain.
(B) Agents when used to promote fertility.
(C) Agents when used for cosmetic purposes or hair growth.
(D) Agents when used for the symptomatic relief of cough and colds.
(E) Agents when used to promote smoking cessation.
(F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
(G) Nonprescription drugs.
(H) Covered outpatient drugs, which 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.
(I) Barbiturates
(J) Benzodiazepines

(4) REQUIREMENTS FOR FORMULARIES — A State may establish a formulary if the formulary meets the following requirements:

(A) The formulary is developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the Governor of the State (or, at the option of the State, the State's drug use review

board established under subsection (g)(3)).

(B) Except as provided in subparagraph (C), the formulary includes the covered outpatient drugs of any manufacturer, which has entered into and complies with an agreement under subsection (a) (other than any drug excluded from coverage or otherwise restricted under paragraph (2)).

(C) A covered outpatient drug may be excluded with respect to the treatment of a specific disease or condition for an identified population (if any) only if, based on the drug's labeling (or, in the case of a drug the prescribed use of which is not approved under the Federal Food, Drug, and Cosmetic Act but is a medically accepted indication, based on information from appropriate compendia described in subsection (k)(6)), the excluded drug does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary and there is a written explanation (available to the public) of the basis for the exclusion.

(D) The state plan permits coverage of a drug excluded from the formulary (other than any drug excluded from coverage or otherwise restricted under paragraph (2)) pursuant to a prior authorization program that is consistent with paragraph (5),

(E) The formulary meets such other requirements as the Secretary may impose in order to achieve program savings consistent with protecting the health of program beneficiaries.

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).

42 USC 1396r-8(k)(6) MEDICALLY ACCEPTED INDICATION -

> The term “medically accepted indication" means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in subsection (g)(1)(B)(i).

The Medicaid Provider Manual provides, in pertinent part, as follows regarding prior authorizations:

8.2 PRIOR AUTHORIZATION REQUIREMENTS

PA is required for:

- Products as specified in the MPPL. Pharmacies should review the information in the Remarks as certain drugs may have PA only for selected age groups, gender, etc. (e.g., over 17 years).
- Payment above the Maximum Allowable Cost (MAC) rate.
- Prescriptions that exceed MDCH quantity or dosage limits.
- Medical exception for drugs not listed in the MPPL.
- Medical exception for noncovered drug categories.
- Acute dosage prescriptions beyond MDCH coverage limits for H2 Antagonists and Proton Pump Inhibitor medications.
- Dispensing a 100-day supply of maintenance medications that are beneficiary-specific and not on the maintenance list.
- Pharmaceutical products included in selected therapeutic classes. These classes include those with products that have minimal clinical differences, the same or similar therapeutic actions, the same or similar outcomes, or have multiple effective generics available.

* * *

8.4 DOCUMENTATION REQUIREMENTS

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

- Pharmacy name and phone number;
- Beneficiary diagnosis and medical reason(s) 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.

* * *

8.6 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.

Medicaid Provider Manual; Pharmacy Section
Version Date: April 1, 2010, Pages 14-16

The Department is authorized by federal law to develop a formulary of approved prescriptions and a prior-authorization process. In this case, the Michigan Department of Community Health PDL & MAP criteria for Attention Deficit/ Hyperactivity Disorder (ADD/ADHD) Agents states:

Ages 18 & + (continuation of interrupted therapy started prior to turning 18): If the patient was treated as a child for ADD/ADHD and now

> presents for an extension of that treatment, this should NOT be considered a case of new, adult onset ADD/ADHD. **PDL criteria apply.** MDCH review required unless the diagnosis or evaluation has been made by a **psychiatrist or a CMH professional after turning 18 years old. Any other specialty description is not acceptable and should be forwarded to a clinical pharmacist for possible MDCH review. Two examples that are not acceptable are ADHD Specialist [Dr. Terry Dickson] and behavioral health specialist.** If MDCH review is necessary, we would need info related to the following:
>
> 1. when the initial diagnosis was made
> 2. when the ADD / ADHD was last treated
> 3. if the patient is still in school, is working, or what the social implications of the diagnosis are
>
> *Michigan Department of Community Health (MDCH) PDL & MAP Criteria, Attention Deficit /Hyperactivity Disorder (ADD/ADHD) Agents,* June 1, 2010, page 55 (emphasis in original). (Exhibit 1, page 7)

The Department's agent reviewed the prior authorization request and information provided against the criteria set forth above. It was determined that the information provided was not sufficient to meet the criteria. There were no records indicating that the diagnosis or evaluation was made by a psychiatrist or a CMH professional. It was sent to MDCH for review, where the Department's physician reviewer denied the request after determining the criteria had not been satisfied with the information provided. Thereafter, a denial notice was mailed to the Appellant.

The Appellant provided testimony that the Appellant has been treating for her medication condition since before she turned [redacted] and it is common to interrupt the medication during summertime, when school is not in session. She stated it is difficult to get her appointments at the CMH because the psychiatrists are not available more than 2 days per month. This makes it difficult to get the prescription written by the same practitioner, thus it looks like she interrupted therapy but she did not. She further testified the general practitioner prescribes the medication when she cannot get into the psychiatrist due to unavailability of appointments through CMH. She also stated she had been diagnosed by a CMH psychiatrist in [redacted]

This ALJ did review the evidence of record to determine whether the criteria was satisfied by the documentation submitted. While it is likely true both that the Appellant only interrupted therapy in the summer when school was not in session and had to obtain prescriptions from her general practitioner due to the difficulty in accessing the psychiatrist, the evidence of record does support the determination that the therapy sought was interrupted therapy. As such, it is necessary to meet the strict Department criteria for re-establishing the need for the medication. The documentation submitted does not establish the Appellant has had a diagnosis made by a CMH professional or psychiatrist since turning [redacted], thus she has not satisfied the criteria necessary to be given the prior

authorization for the medication sought. While this ALJ is sympathetic to the Appellant's plight, the Department's denial was proper based upon the information received with the prior authorization request. The Appellant is free to re-submit the request for prior authorization at any time. She may wish to have a different provider submit the prior authorization request who has access to the needed information and documentation to support the prior authorization criteria.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, must find that the Department was within its legal authority to deny coverage for the Medication sought.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 12/10/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 for the Department of Community Health 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.