STATE OF MICHIGAN
MICHIAGAN ADMINISTRATIVE HEARINGS SYSTEM
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]

Docket No. 2011-25314 QHP
Case No. [redacted]

Appellant
_____/

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]. The Appellant was present and testified on her own behalf. The Respondent, [redacted], was represented by [redacted], and [redacted], [redacted]

ISSUE

Did the Respondent properly deny the Appellant's request for Adipex-P?

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 Respondent, [redacted] is a Department of Community Health contracted Medicaid Health Plan (MHP).

2. The Appellant is a [redacted] Medicaid beneficiary, who is enrolled in the Respondent MHP. (uncontested)

3. The Appellant is overweight and suffers additional medical ailments which result of shortness of breath.

4. The Appellant's physician has prescribed the weight loss drug Adipex-P and submitted a request for prior authorization to the MHP.

5. Documentation submitted indicates the Appellant's weight at the time of submission was 172 pounds. Her height is 5'1". Thus her body mass index (BMI) is 32.5.

6. On [redacted], the MHP sent the Appellant notice that the request for Adipex-P was denied because her body mass index did not meet the prior authorization requirement of at least 33.

7. On [redacted], the Department received the Appellant's Request for Hearing.

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. The Contractor 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 2.024.
>
> *Section 1.022(E)(1), Covered Services.*
> *MDCH contract (Contract) with the Medicaid Health Plans,*
> *October 1, 2009.*

> (1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:
>
> (a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.

(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
(e) The Um activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure
The Contractor must establish and use a written prior approval policy and procedure for UM 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Section 1.022(AA), Utilization Management, Contract, October 1, 2009.

As stated in the Department-MHP contract language above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent sections of the Michigan Medicaid Provider Manual (MPM) are as follows:

SECTION 6 – GENERAL NONCOVERED SERVICES

The following drug categories are **not covered** as a benefit:

* * *

- Agents used for anorexia or weight loss.

Department of Community Health, Medicaid Provider Manual, Pharmacy Version Date: April 1, 2010, Page 12

SECTION 7 – DELIVERY OF SERVICES

7.3 NONCOVERED SERVICES

When the beneficiary needs a medical service recognized under State Law, but not covered by Medicaid, the service provider and the beneficiary must make their own payment arrangement for that noncovered service. The beneficiary must be informed, prior to rendering service, that Medicaid does not cover the service.

Department of Community Health,
Medicaid Provider Manual,
General Information for Providers
Version Date: April 1, 2010, Page 12

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.

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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.

8.5 ADDITIONAL DOCUMENTATION

Depending on the specific drug being prescribed, additional medical documentation may be required.

The most common categories requiring additional documentation are:

8.5.A. BRAND OVERRIDE

Provide documentation of the therapeutic trial and failure reasons of the generic.

8.5.B. WEIGHT LOSS

- Current medical status, including nutritional or dietetic assessment.
- Current therapy for all medical conditions, including obesity.
- Documentation of specific treatments, including medications.
- Current accurate Body Mass Index (BMI), height, and weight measurements.
- Confirmation that there are no medical contraindications to reversible lipase inhibitor use; no malabsorption syndromes, cholestasis, pregnancy and/or lactation.
- Details of previous weight loss attempts and clinical reason for failure (at least two failed, physician supervised, attempts are 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.

Department of Community Health
Medicaid Provider Manual
Pharmacy Chapter
Version Date: April 1, 2011, Pages 14, 15, 16

The MHP explained that it denied the Appellant's request because the Appellant's BMI was inadequate to meet the PA requirements. That is the sole reason cited in the denial notification. The criteria submitted by the QHP indicates there are additional criteria which would be considered. The BMI is the sole reason cited in the denial letter, thus it is the only criteria considered at this hearing.

The Appellant did seek to contest the denial on the basis of her BMI by stating her weight has increased since the time PA was sought. She did not submit clinical documentation to support her claim, nor was her current weight able to be considered at the time PA was sought. The Appellant is encouraged to re-submit a request for PA should her current weight satisfy the written criteria that has been supplied to her. It is noted the remaining criteria will be considered should she re-submit her request for PA.

While this ALJ sympathizes with the Appellant's circumstances, the MHP's denial must be upheld. Policy in this case is clear: the weight loss drug sought has stipulations regarding BMI and other factors which must be considered. The MHP could only consider the weight and height as reported on the request for PA when it made its determination. Based upon the criteria, it was proper to deny the request due to the documentation showing the Appellant's BMI did not meet or exceed 33.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that the Medicaid Health Plan properly denied the Appellant's request for Adipex-P.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

_____
Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

[redacted]
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Decision and Order

cc: [redacted]

Date Mailed: 5/12/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.