STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING 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. 2012-50453 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.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on Tuesday [redacted]. The Appellant appeared without representation. He had no witnesses. [redacted] represented [redacted], the [redacted]. Her witness was [redacted].

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for [redacted]?

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 [redacted] Medicaid beneficiary. (Appellant's Exhibit #1)

2. The Appellant is afflicted with [redacted]. (See Testimony and Respondent's Exhibit A, page 7)

3. His physician, on [redacted] prescribed [redacted]. (Respondent's Exhibit A, pages 1, 2, 7 and 8)

4. On [redacted] the MHP advised the prior authorization (PA) requestor that the MHP requires a tiered approach of try-fail of alternative medications [redacted] before consideration and approval of [redacted].

(Respondent's Exhibit A, page 2)

5. The Respondent's witness testified that he Appellant had not completed a trial on alternative medications. (See Testimony)

6. The requesting healthcare provider and the Appellant were advised of the denial on [redacted] His further appeal rights were contained therein. (Respondent's Exhibit A, pages 2 and 3)

7. The instant request for hearing was received by the [redacted] on [redacted]. (Appellant's Exhibit #1)

CONCLUSIONS OF LAW

The Medic al Ass istance Program is establis hed purs uant to Tit le XIX of t he Soc ial Security Act and is im plemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with stat e statute, the Social Welfare Act, the Administrative Code, and the State Plan under Titl e XIX of the Social Security Act Medical Assistance Program.

On [redacted] the Department received appr oval from the Health Car e Financing Administration, U.S. Department of Health and Human Serv ices, allowing Michigan t o restrict Me dicaid beneficiari es' choice to obtain medical services only from specified Medicaid Health Plans.

The Respondent Health Plan of Michigan is one of those Medicaid Health Plans.

> The cover ed services that the Contractor has available for enrollees must include, at a mi nimum, the covered services listed below. The Contractor may limit services to those which are medically necessary and appropriate, and whic h conform to professionally acce pted standards of care. The Contractor must operate cons istent wit h al l applicable Medicaid provider manuals an d publications for coverages and limitations. If new servic es are added to the Michigan Medicaid Program, or if serv ices are expanded, elimin ated, or otherwise changed, the Contra ctor must implement the changes c onsistent with State di rection in accordanc e with the provisions of Contract Section 2.024.
>
> Although the Contractor must provide t he full range of covered services listed below they may choose to provide services over and above thos e specifie d. The c overed services pr ovided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testi ng in accordanc e with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedur es, lim ited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or re habilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maxi mum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included se rvices, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometri sts and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disab ilities which are bille d throug h

Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2010, p. 22.

....

Utilization Management

(1) The major components of the Contractor's utilization management (UM) program 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 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.

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Contract, *Supra,* at page 49.

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The MHP witness testified that the Appellant failed to meet plan requirements under utilization management guidelines for approval of the requested drug; [redacted] - for lack of completing a try-fail program of alternative topical medications [*See* Finding of Fact #4]

[redacted] testified that the Appellant was at "the beginning" of the try-fail requirement and that he had many more medications to try.

The Appellant testified that tried [redacted] without success and that he understood the [redacted] try-fail requirement. He said he would further discuss the matter with his physician.

The Petitioner has the burden of proving by a preponderance of evidence that the requested medication was medically necessary – and that he completed or gave good effort at meeting the health plan's try-fail requirement.

The MHP established in its PA review and testimony that Appellant did not demonstrate completion of try-fail of alternative medications.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director

cc: [redacted]

Date Mailed: _____

***** 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.