

**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:

██████████,

Appellant

Docket No. 2012-21569 PHR  
Case 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 ██████████. The Appellant appeared without representation. He had no witnesses. ██████████, RPH Manager, represented the Department. She had no witnesses.

**PRELIMINARY MATTER**

The admission of Appellant's Exhibit #2 was taken under advisement at hearing. On review it is admitted and afforded modest weight.

**ISSUE**

Did the Department properly deny Appellant's request for reimbursement of out of pocket expense for the medication Adderall XR?

**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 ██████-year-old Medicaid beneficiary. (Appellant's Exhibit #1)
2. The Appellant is afflicted with "sleep deprivation" and Narcolepsy. (Appellant's Exhibit #1 and Department's Exhibit A, page 4)
3. In ██████████ the Appellant paid out of pocket for Adderall XR at a ██████████ pharmacy – even though he had active coverage. (Department's Exhibit A, page i)

4. According to the Department neither the pharmacy nor the physician contacted the MMA for a PA, although the PA was approved when received. (Department's Exhibit A, page i)
5. The Appellant submitted evidence that he had been reimbursed by ██████████ pharmacy in the past. (Appellant's Exhibit #2)
6. The instant request for appeal was received by the Michigan Administrative Hearing System (MAHS) for the Department of Community Health on ██████████. (Appellant's Exhibit #1)

### **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)]

#### 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.

##### (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).

(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 sets forth significant guidelines for charging or not charging Medicaid beneficiaries:

#### **NONALLOWABLE CHARGES TO THE BENEFICIARY**

A pharmacy must not charge a beneficiary for a prescription if the pharmacy or prescriber fails to request prior authorization (PA). For all products listed in the MPPL indicating PA is required, the pharmacy may contact the PBM for PA or notify the prescriber that a PA is needed.

A pharmacy may charge the beneficiary its U&C charge for a product requiring PA only if the pharmacy has written documentation that the beneficiary was informed of the attempt and failure to obtain PA and of the resultant desire to purchase the drug privately. The pharmacy must not charge any portion of this claim to Medicaid.

The beneficiary must be made aware that PA and reimbursement cannot be obtained later.

MPM, Pharmacy, §13.7 Nonallowable Charges [ ]  
January 1, 2012, pages 24 and 25<sup>1</sup>

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The Department witness, ██████████, testified that the requested drug was designed to help treat ADHD, narcolepsy and chemotherapy related fatigue. She added that the medication was approved and that the Appellant had active coverage – there was no need to pay out of pocket. She suggested that the Appellant seek reimbursement from ██████████ Pharmacy.

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<sup>1</sup> This version of the MPM is identical to the edition in place on the date of Appellant's appeal.

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The Appellant said he wanted his money back. He said his doctor sent "information" to the wrong health plan.

In review, based on the testimony of Department witness [REDACTED], I find that the Appellant has failed to preponderate his burden of proof. The medication was approved, he had active coverage so there was no reason to pay out of pocket for Adderall XR.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for reimbursement of out of pocket expenses incurred in purchasing the approved medication – Adderall XR.

**IT IS THEREFORE ORDERED** that:

The Department's decision is **AFFIRMED**.

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Dale Malewska  
Administrative Law Judge  
for Olga Dazzo, Director  
Michigan Department of Community Health

cc:



Date Mailed: 3/16/2012

**\*\*\* 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.