

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

Docket No. 2012-46330 QHP

██████████

██████████ ██████████

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 ██████████. The Appellant represented himself. The Respondent, ██████████ Health Plan of Michigan, Inc., was represented by ██████████ ██████████, Director of Member Services; ██████████ ██████████, Clinical Pharmacist for the plan was present and testified. ██████████ was present on behalf of the health plan.

ISSUE

Did the Respondent properly deny the Appellant's request for Incivek?

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, ██████████ Health Plan of Michigan, Inc., is a Department of Community Health contracted Medicaid Health Plan (MHP).
2. The Appellant is a Medicaid beneficiary who was enrolled in the Respondent MHP. (uncontested)
3. The Appellant's physician submitted a prior authorization request for Incivek on or about ██████████
4. The requested medication is a non-formulary medication for Meridian Health Plan of Michigan.
5. The MHP reviewed the request for Incivek under its non-formulary exception criteria and determined that denial was proper because there was no evidence of trial and failure of the formulary equivalent.

6. The MHP notified the Appellant of the denial determination ██████████ and he thereafter requested an internal appeal.
7. The internal appeal was forwarded to a pharmacist for review along with all supporting documentation received by the MHP. The first level appeal was denied ██████████
8. On ██████████, 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." Finally, the Contract also requires that:

[Pharmacy]

- (a) The Contractor may have a prescription drug management program that includes a drug formulary. DCH [the Department] may review the Contractor's formularies regularly, particularly if enrollee complaints regarding access have been filed regarding the formulary. The Contractor agrees to have a process to approve physician's requests to prescribe any medically

appropriate drug that is covered under the Medicaid FFS program.

Contract §II-H (8) p. 39

The MHP explained that it denied the Appellant's request for Incivek because it is non-formulary. It identified the formulary alternative that must specifically be trialed and found ineffective or be contraindicated before the plan's formulary exception process would have to be fully completed. No evidence of record establishes a trial and failure of the formulary medication or that it is contraindicated.

The Appellant asserts he is being denied treatment for his medical condition. He asserted he had never been informed there was an alternative medication or treatment. He said his doctor told him emphatically that the health plan said no treatment was approved. He admitted he had a copy of the denial notice sent him. The denial notice explicitly identifies the formulary alternative medication.

The evidence of record supports the position held by ██████████ Health Plan of Michigan. The contract between MDCH and the MHP allows establishment of a formulary and prior authorization process. In this case the medication requested is non-formulary and utilization control process authorized by MDCH allows for the process to require exhaustion of the formulary alternative prior to invoking the exception process. There is no evidence to support the Appellant's assertion that he is being denied treatment for his condition. The Notice sent him and his provider explicitly identifies the formulary alternative medication, thus refutes his assertion he was denied treatment. The determination by the MHP's physician and pharmacist is correct under the contract provisions and policy.

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 Incivek.

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

Cc: ██████████

Date Mailed: 5-31-12

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Decision and Order

***** 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.