

**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) 373-4147

IN THE MATTER OF:

Docket No. 2013-35519 QHP

██████████,

██████████

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.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████ ██████████ husband, represented the Appellant. ██████████, Paralegal, represented ██████████ ██████████ the Medicaid Health Plan (MHP). ██████████ Plan Medical Director, appeared as a witness for the MHP. The record was left open for the MHP to submit additional documentation, which has been received.

**ISSUE**

Did the MHP properly deny the Appellant's request for the medication Zomig?

**FINDINGS OF FACT**

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is a Medicaid beneficiary who is currently enrolled in the Respondent MHP, ██████████
2. On or about ██████████ the MHP received a request for the medication Zomig for the Appellant. The available information indicated the Appellant had tried Maxalt and sumatriptan, but not naratriptan. (Exhibit B)

3. On ██████████, the MHP sent the Appellant notice that the request for the medication Zomig was denied because it does not meet the health plan's reason(s) for an exception to the Medicaid Preferred Drug List, also known as the formulary. Coverage for the requested medication would be provided in situations where the patient has tried and failed treatment with sumatriptan. Maxalt and Naratriptan are also preferred alternatives after a trial and failure of, or contraindication with sumatriptan. (Exhibit A)
4. On ██████████, the Appellant's Request for Hearing was received by the Michigan Administrative Hearing System.

### **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 MHPs.

The Respondent is one of those MHPs.

The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below. 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.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance 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 procedures, limited 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 rehabilitative 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 – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists 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 disabilities which are billed through 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/EPSTD for persons under age 21

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

- (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.

....

Contract, *Supra*, p. 49

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP Director of Medicaid explained that the MHP has a formulary. Zomig is a non-preferred medication. The MHP requires documented trial/failure of all of the preferred products before a non-preferred medication can be considered. For the requested medication of Zomig, the preferred medications are sumatriptan (Imitrex), rizatriptan (Maxalt) and naratriptan (Amerge). (Exhibit C) The MHP reviewed the available information, which did not indicate that this criterion was met. The Appellant had only tried sumatriptan and Maxalt. Accordingly, the MHP denied the Appellant's request for Zomig. (Exhibit A-B; Plan Medical Director Testimony)

The Appellant disagrees with the denial. The Appellant's husband testified that before moving to Michigan, the Appellant used Zomig. The Appellant has had chronic migraines for years. The Appellant's husband stated it is not fair to have to wait to see if other medications work. (Husband Testimony)

The MHP provided sufficient evidence that its formulary and medication prior approval process is consistent with Medicaid policy and allowable under the DCH-MHP contract provisions. The MHP demonstrated that at the time the denial decision was made, the Appellant did not meet criteria for approval of Zomig because the available information did not establish a trial and failure, or contraindication with naratriptan. Accordingly, the MHP's determination must be upheld.

However, the Appellant's husband's testimony indicated that the Appellant has begun a trial with naratriptan. (Husband Testimony) If the trial with naratriptan is not successful, a new prior authorization request for Zomig can be submitted to the MHP with additional documentation, such as trial and failure with all three of the preferred formulary medications.

### **DECISION AND ORDER**

The ALJ, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for the medication Zomig based on the available information.

[REDACTED]  
Docket No. 2013-35519 QHP  
Decision and Order

**IT IS THEREFORE ORDERED** that:

The Medicaid Health Plan's decision is **AFFIRMED**.

/s/

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Colleen Lack  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

CL/db

cc: [REDACTED]

**\*\*\* 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.