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:

[redacted],

Appellant

Docket No. 14-010762 QHP
Case No. [redacted]

/

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 [redacted]. The Appellant was represented by Kisha Hernandez, mother.

HealthPlus Partners, Inc. was represented by [redacted], Staff Attorney. [redacted] is a Department of Community Health contracted Medicaid Health Plan (MHP). [redacted], Fair Hearings Coordinator, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request Prior Approval (PA) request for an Ortho Evra Patch?

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] year-old Medicaid beneficiary.

2. On or about [redacted], the MHP received a PA request for an Ortho Evra Patch on behalf of Appellant. (Exhibit B).

3. The Appellant is diagnosed with premenstrual syndrome and needs the patch due to "patient forgets to take daily." (Exhibit B).

4. Appellant is 63 inches and weighs 262 pounds. Appellant's BMI is 46.4. (Exhibit B).

5. On [redacted], the MHP sent the Appellant and her physician notice that the request was denied. (Exhibit D).

6. On [redacted] a secondary review was conducted by an HPP Board Certified Medical Director, an MD, specializing in Family Practice that was not involved in the initial request. The review affirmed the previous denial. (Exhibit E).

7. The MHP and subsequent review denied on the grounds that Appellant had not meet certain medical conditions for coverage as required by the Drug Formulary as her physician did not indicate that she has tried and failed previous generic medications. (Exhibit E).

8. The policy in the Michigan Department of Community Health Medicaid Provider Manual requires that alternative treatment be pursued. (Section 8.6)

9. Ortho Evra research has indicated that individuals whose body weight is over 198 pounds do not have the same success/effectiveness with the drug. (Exhibit C).

10. On [redacted], the Michigan Administrative Hearing System received the Request for Hearing submitted on the Appellant's behalf.

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.

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 (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:

- 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. <u>Prior Approval Policy and Procedure</u>

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,
MDCH contract (Contract) with the Medicaid Health Plans,

October 1, 2009

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.

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 are as follows:

Department of Community Health,
Medicaid Provider Manual, Outpatient Therapy Section
Version Date: October 1, 2012, Pages 19-21.

The MHP follows a certain Formulary Drug Product standards. (Exhibit C). Applicable to the case here and with regard to contraceptives, including Ortho Evra, the Formulary requires, in part:

> The patient must have a documented trial or Rx claims for at least 2 generically available oral contraceptives in the past year before any brand product will be covered. (Exhibit C.2).

The Appellant's mother testified that her daughter has PMDD, and has a hard time taking pills and forget sometimes. However, while such considerations for a teen may be understandable, such concerns do not fall under the guidelines of the MHP contract for the Medicaid plan she is on with the State of Michigan. As noted above, Appellant must show a failure of at least 2 generically available oral contraceptives in the year prior to the request. (See Exhibit C). None was shown here. This requirement is consistent with the parameters of the Medicaid Provider Manual. As such, this ALJ must uphold the denial. Accordingly, the MHP denial was consistent with the Medicaid policy and must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that that the MHP properly denied the Appellant's request for an Ortho Evra Patch.

IT IS THEREFORE ORDERED that:

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

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

cc: [redacted]

JS/[redacted]

Date Signed: [redacted]

Date Mailed: [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.