

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:

██████████,

Appellant

CASE INFORMATION

Docket No.: 15-001346 MHP

Case No.: ██████████

Appellant: ██████████

Respondent: ██████████

HEARING INFORMATION

Hearing Date: ██████████

Start Time: ██████████

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 telephone hearing was held on ██████████. Appellant appeared and testified on his own behalf. Respondent ██████████ (MHP) was represented by ██████████), Authorized Hearings Representative and ██████████, Manager of ██████████

Respondent's Exhibit A pages 1-75 were admitted as evidence without objection.

ISSUE

Did the MHP properly deny the Appellant's request for Propecia?

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. ██████████ (MHP) is a Qualified Health Plan contracted with the State of Michigan Comprehensive Health Care Program.

2. Appellant is a Medicaid benefit recipient, date of birth [REDACTED], who was an enrolled member of [REDACTED] at the time of the request for services and continues to be enrolled.
3. The MHP member handbook and certificate of coverage were sent at the time of enrollment.
4. The Member Handbook outlines covers limitations, prior authorization requirements, limitations and exclusions, and pharmacy guidelines.
5. On [REDACTED], [REDACTED] received a request for Propecia 1mg Tablet.
6. On [REDACTED] denied the request, as the medication is not a covered benefit on the [REDACTED] Medicaid Formulary.
7. On [REDACTED], [REDACTED] sent Appellant notice of the denial for Procepia 1mg Tablet.
8. On [REDACTED] the request for Propecia 1mg Tablet was re-reviewed and the decision to deny the request was upheld.
9. On [REDACTED], the Michigan Department of Community Health received a Request for hearing from Appellant, contesting the MHP's negative action.
10. On [REDACTED], the MHP sent Appellant written notice that his request was re-reviewed and remained denied.
11. Respondent provided Appellant with a copy of the Hearing Summary and attached Exhibits.

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].

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.”

Medicaid Provider Manual, Pharmacy Section 6, page 12 – General Noncovered Services states that agents used for cosmetic purposes or hair growth are not covered as a benefit.

Appellant testified that he has been using a similar drug – Finasteride 5mg since he was [REDACTED] years and enrolled with a different provider. He loses chunks of hair and it has impacted him psychologically and physically.

Appellant has failed to satisfy his burden of proving by a preponderance of the evidence that the MHP improperly denied the request for Propecia 1mg Tablet. In the instant case, the conditions required for coverage were not met based upon the medical information submitted with the Prior Authorization request.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP’s denial of the Appellant’s request for Propecia 1mg Tablet was proper.

IT IS THEREFORE ORDERED that:

The MHP’s decision is **AFFIRMED**.

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

[REDACTED]
Docket No. 15-001346 MHP
Decision and Order

LYL/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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.