STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
Phone: (877)-833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],
Appellant
_____/

CASE INFORMATION

Docket No.: 15-007303-MHP
Case No.: [redacted]

Appellant:
[redacted]

Respondent:
[redacted]

HEARING INFORMATION

Hearing Date: [redacted]
Start Time: [redacted]

Location
Telephone Hearing

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 [redacted] Appellant appeared and testified on her own behalf. Respondent Priority Health Choice (MHP) was represented by Jeff Greshak, Manager of Medicaid Operations.

ISSUE

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

FINDINGS OF FACT

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

1. Appellant is a [redacted] (DOB [redacted]) Medicaid beneficiary. (Exhibit A, p. 7)

2. On or about [redacted] the MHP received Prior Authorization Requests from [redacted], on behalf of the Appellant for [redacted] 50 mg/mL (0.98mL) Sub-Q Pen Injector. (Exhibit A, pp. 7-9).

3. On [redacted], the MHP sent [redacted] and the Appellant notice denying the prior authorization request as the Appellant did not satisfy the coverage criteria outlined in the MHP's drug policy. Specifically that the Appellant had not tried phototherapy. (Exhibit A, pp. 11-18; Testimony)

4. On or around [redacted], Dr. Nykamp's office informed the MHP that the Appellant had tried phototherapy for 5 years. (Exhibit A, p. 25; Testimony)

5. On or around [redacted], MHP inquired as to whether or not Raptiva qualified as a non-biologic medication as required by the MHP drug policy. (Exhibit A, p. 25; Testimony)

6. On or around [redacted] MHP discovered Raptiva did not qualify as a non-biologic medication as it was a biologic medication. (Exhibit A, p. 25; Testimony)

7. On or around [redacted], MHP informed [redacted] office that the Appellant did not meet the requirements of their drug policy as the Appellant had not tried a non-biologic medication. (Exhibit A, p. 25)

8. On [redacted], MHP sent the Appellant and [redacted] office a notice indicating the Appellant had not tried a non-biologic systemic drug. (Exhibit A, pp. 29, 30; Testimony)

9. On [redacted], MHP sent [redacted] office a request for additional information related to the Appellant's prior use of at least one systemic treatment (non-biologic). (Exhibit A, p. 33; Testimony)

10. On [redacted], MHP sent the Appellant a letter. The letter indicated that MHP had sent [redacted] a request for additional information and that without a response from [redacted] office, the prior authorization request would continue to be denied. (Exhibit A, pp. 46, 47; Testimony)

11. On [redacted], the Appellant filed a Request for Hearing with the Michigan Administrative Hearing System (MAHS). (Exhibit A, p. 4; Testimony)

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 but may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of

the diagnosis, type of illness, or condition of an enrollee. In general, the Contractor is responsible for covered services related to the following:

- The prevention, diagnosis, and treatment of health impairments
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain, or regain functional capacity

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 (only for enrollees under 21 years of age)
- 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 in accordance with Medicaid policy as stated in the Medicaid Provider

Manual, Mental Health/Substance Abuse Chapter, Beneficiary Eligibility Section

- 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/EPSDT for persons under age 21 [Article 1, 1.022 Work and Deliverables, at §1.022 E (1) contract, 12/5/2013, pp. 22-23].

* * *

(7) Pharmacy

The Contractor may have a prescription drug management program that includes a drug formulary. DCH may review the Contractor's formularies regularly, particularly if enrollee complaints regarding access have been filed regarding the formulary. The Contractor must have a process to approve physicians' requests to prescribe any medically appropriate drug that is covered under the Medicaid Pharmaceutical Product List (MPPL). [Article 1, 1.022 Work and Deliverables, at §1.022 E (7) contract, 12/5/2013, p. 27].

* * *

AA. Utilization Management

(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. 55].

The *Medicaid Provider Manual*, *Pharmacy*, Section 7, July 1, 2014, references the list of pharmaceutical products that are covered by the MDCH under Medicaid. This section states:

> **SECTION 7 - MICHIGAN PHARMACEUTICAL PRODUCT LIST**
>
> The Michigan Pharmaceutical Product List (MPPL) identifies the pharmaceutical products that are covered by MDCH. The MPPL pharmaceutical product coverages may vary by MDCH program or be limited by age, clinical parameters, and/or gender. The Point of Sale pharmacy claim adjudication also provides coverage information related to a specific beneficiary or prescription.
>
> The MPPL is posted on the PBM's website. (Refer to the Directory Appendix for website information.) Providers must refer to the MPPL for the additions and deletions of drug products. Specific notification of changes will not be issued. [*Medicaid Provider Manual*, *Pharmacy*, Section 7, p. 13, July 1, 2014].

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The DCH-MHP contract provisions also allow the MHP to have a drug management program that includes a drug formulary. The MHP reviewed the prior authorization request under their Priority Health Handbook and Certificate of Coverage. The MPH noted that the requested medication was on their formulary but required prior authorization which included satisfying six requirements. And that the Appellant in this matter failed to satisfy one of those requirements (one systemic treatment).

The Appellant did not provide any testimony and failed to satisfy her burden of proving by a preponderance of the evidence that the MHP improperly denied the request for Enbrel. 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 Enbrel was proper.

IT IS THEREFORE ORDERED that:

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

Corey Arendt
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of Health and Human Services

cc: [redacted]

CA/hj

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.