Date Mailed: February 17, 2026
Docket No.: 25-046041
Case No.: [redacted]
Petitioner: [redacted]

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* and upon a request for a hearing filed by Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on January 27, 2026. Petitioner appeared and testified on her own behalf. Almeta Hunt, a Senior Clinical Pharmacist with Prime Therapeutics, appeared and testified on behalf of the Respondent Michigan Department of Health and Human Services (Respondent or MDHHS).

During the hearing, Respondent submitted an evidence packet that was admitted into the record without objection as Exhibit A, pages 1-36. No other proposed exhibits were submitted.

ISSUE

Did Respondent properly deny Petitioner's prior authorization request for methylphenidate ER (LA)?

FINDINGS OF FACT

The ALJ, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Prime Therapeutics contracts with MDHHS to review prior authorization requests for specified medications. (Testimony of Respondent's representative).

2. On October 25, 2025, Prime Therapeutics received a prior authorization request for methylphenidate ER (LA) submitted on Petitioner's behalf by Petitioner's doctor. (Exhibit A, pages 9-16).

3. That request and supporting documentation indicated that Petitioner had been diagnosed with attention deficit hyperactivity disorder (ADHD), predominately inattentive type and that she was to take methylphenidate ER (LA) daily for that diagnosis. (Exhibit A, page 9).

4. However, they did not identify the basis for that diagnosis or what other medications had been ruled out or found to be inappropriate. (Exhibit A, pages 9-16; Testimony of Respondent's representative).

5. Based on that clinical information, Prime Therapeutics determined that it could not approve Petitioner's request. (Testimony of Respondent's representative).

6. Prime Therapeutics, therefore, forwarded the request to MDHHS for a review by a MDHHS physician. (Testimony of Respondent's representative).

7. On November 25, 2025, the MDHHS physician reviewed the request and determined that it should be denied because it did not meet criteria for approval. (Exhibit A, page 8).

8. Prime Therapeutics sent Petitioner's doctor an electronic notice of denial that same day. (Exhibit A, page 17).

9. In part, that notice stated:

> Denied; Does not meet multiple criteria for approval with information submitted. Non-preferred medication and PDL not met. No documentation was submitted that supports the diagnosis of ADHD in an adult in the setting of stimulant utilization. Please reference posted coverage criteria at MI Medicaid Clinical and PDL PA Criteria (primetherapeutics.com) - Documents - Other Drug Information - Clinical And PDL PA Criteria, then search "ADHD" noting the diagnosis in an adult."
>
> *Exhibit A, page 17*

10. On November 25, 2025, Prime Therapeutics also sent Petitioner written notice that her prior authorization request for methylphenidate ER (LA) had been denied because it did not meet criteria. (Exhibit A, pages 18-22).

11. On December 17, 2025, MOAHR received the request for hearing filed by Petitioner in this matter with respect to the denial of her request. (Exhibit A, pages 3-6).

12. After the request for hearing was filed in this case, Petitioner's doctor submitted new prior authorization request on Petitioner's behalf, along with additional information, and Petitioner was approved for methylphenidate ER (LA). (Testimony of Petitioner; Testimony of

Respondent's representative).

CONCLUSIONS OF LAW

The Medical Assistance Program was 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 Social Security Act § 1927(d), 42 USC 1396r-8(d), also provides as follows:

> (d) Limitations on Coverage of Drugs –
>
> (1) Permissible Restrictions –
>
> (A) A State may subject to prior authorization any covered outpatient drug. Any such prior authorization program shall comply with the requirements of paragraph (5).
>
> (B) A State may exclude or otherwise restrict coverage of a covered outpatient drug if –
>
> (i) the prescribed use is not for a medically accepted indication (as defined in subsection (k)(6);
>
> (ii) the drug is contained in the list referred to in paragraph (2);
>
> (iii) the drug is subject to such restriction pursuant to an agreement between a manufacturer and a State authorized by the Secretary under subsection (a)(1) or in effect pursuant to subsection (a)(4); or
>
> (iv) the State has excluded coverage of the drug from its formulary in accordance with paragraph 4.
>
> (2) List of drugs subject to restriction–The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:

(A) Agents when used for anorexia, weight loss, or weight gain.

(B) Agents when used to promote fertility.

(C) Agents when used for cosmetic purposes or hair growth.

(D) Agents when used for the symptomatic relief of cough and colds.

(E) Agents when used to promote smoking cessation.

(F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

(G) Nonprescription drugs, except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

(H) Covered outpatient drugs, which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

(I) Barbiturates.

(J) Benzodiazepines.

(K) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

* * *

(4) Requirements for formularies — A State may establish a formulary if the formulary meets the following requirements:

(A) The formulary is developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the Governor of the State (or, at the option of the State, the State's drug use review board established under subsection (g)(3)).

(B) Except as provided in subparagraph (C), the formulary includes the covered outpatient drugs of any manufacturer, which has entered into and complies with an agreement under subsection (a) (other than any drug excluded from coverage or otherwise restricted under paragraph (2)).

(C) A covered outpatient drug may be excluded with respect to the treatment of a specific disease or condition for an identified population (if any) only if, based on the drug's labeling (or, in the case of a drug the prescribed use of which is not approved under the Federal Food, Drug, and Cosmetic Act but is a medically accepted indication, based on information from appropriate compendia described in subsection (k)(6)), the excluded drug does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary and there is a written explanation (available to the public) of the basis for the exclusion.

(D) The State plan permits coverage of a drug excluded from the formulary (other than any drug excluded from coverage or otherwise restricted under paragraph (2)) pursuant to a

Prior Authorization program that is consistent with paragraph (5),

(E) The formulary meets such other requirements as the Secretary may impose to achieve program savings consistent with protecting the health of program beneficiaries.

A prior authorization program established by a State under paragraph (5) is not a formulary subject to the requirements of this paragraph.

(5) Requirements of Prior Authorization programs—A State plan under this title may require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, with respect to drugs dispensed on or after July 1, 1991, the approval of the drug before its dispensing for any medically accepted indication (as defined in subsection (k)(6)) only if the system providing for such approval –

(A) Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

(B) Except with respect to the drugs referred to in paragraph (2) provides for the dispensing of at least 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

Exhibit A, pages 26-28

Moreover, with respect to pharmaceutical products, the applicable version of the Medicaid Provider Manual (MPM) also provides in part:

SECTION 1 – GENERAL INFORMATION

Michigan Department of Health and Human Services (MDHHS) administers the fee-for-service (FFS) programs for Medicaid, Healthy Michigan Plan, Children's Special Health Care Services (CSHCS), and Maternity Outpatient Medical Services (MOMS). This chapter, the Michigan Pharmaceutical Product List (MPPL), and the Michigan

Preferred Drug List (PDL)/Single PDL comprise program policies and explain coverage and reimbursement for the services dispensed and billed by enrolled pharmacies.

* * *

1.7.A. CARVE-OUT EXCEPTIONS

Select drugs and classes may be carved-out from the respective health plan's reimbursement and paid Medicaid Fee For Service. (Refer to the PBM website listed in the Directory Appendix for a listing of these drug classes.)

Any services paid Fee For Service must follow appropriate guidelines for supporting documentation, including attending, billing, prescribing, referring, rendering and supervising provider requirements

* * *

SECTION 2 – PRESCRIBER REQUIREMENTS

All MDHHS-covered legend and over-the-counter drugs (OTCs), except condoms, require a prescription order by a licensed professional acting within their scope of practice as defined by state and federal laws, rules, and regulations.

Coverage of pharmaceutical products is based on limitations stated in this chapter, the MPPL, and medical necessity. Determination of medical necessity and appropriateness of service is the responsibility of the prescribing physician/provider (prescriber) within the scope of currently accepted medical practice and MDHHS limitations . . .

* * *

SECTION 7 - MICHIGAN PHARMACEUTICAL PRODUCT LIST

The Michigan Pharmaceutical Product List (MPPL) identifies the pharmaceutical products that are covered by MDHHS. The MPPL pharmaceutical product coverages may vary by MDHHS 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.

* * *

SECTION 8 – PRIOR AUTHORIZATION

8.1 PRIOR AUTHORIZATION PROCESSOR

The MDHHS PBM processes prior authorizations (PAs). Refer to PBM's Pharmacy Claims Processing Manual for PA procedures. (See Directory Appendix for contact information.) Authorization to override denial edits must be obtained from the PBM.

Do **not** call the PBM's Call Centers for:

- Supplies billed by Medical Suppliers, including enteral formula and Total Parenteral Nutrition (TPN), since these are only reimbursed to a Medical Supplier provider. Contact the MDHHS Program Review Division for PA. (Refer to the Directory Appendix for contact information.)

- Information about the member's MHP. The provider must contact the MHP to obtain their policies.

8.2 PRIOR AUTHORIZATION REQUIREMENTS

PA is required for:

- Products as specified in the MPPL. Pharmacies should review the information in the Remarks as certain drugs may have PA only for selected age groups, gender, etc. (e.g., over 17 years).

- Payment above the Maximum Allowable Cost (MAC) rate.

- Prescriptions that exceed MDHHS quantity or dosage limits.

- Medical exception for drugs not listed in the MPPL.

- Medical exception for noncovered drug categories.

- Acute dosage prescriptions beyond MDHHS coverage limits for H2 Antagonists and Proton Pump Inhibitor medications.

- Dispensing a 100-day supply of maintenance medications that are beneficiary-specific and not on the maintenance list.

- Pharmaceutical products included in selected therapeutic classes. These classes include those with products that have minimal clinical differences, the same or similar therapeutic actions, the same or similar outcomes, or have multiple effective generics available.

* * *

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 MDHHS clinical review criteria.

- Documentation required was not provided.

The PBM reviews the information submitted to determine whether the clinical criteria have been met. If the submitted information does not indicate that the criteria have been met, the PA is then sent to the Office of Medical Affairs in

MDHHS for final determination on whether the clinical criteria have been met.

MPM, October 1, 2025 version
Pharmacy Chapter, pages 1, 6, 8, 16-17, 19

The Department is, therefore, authorized by federal law to develop both a formulary of approved or limited prescriptions and a prior authorization process.

It has also done so here, with an initial review conducted by Prime Therapeutics and any secondary, final review conducted by MDHHS.

Specifically, with respect to central nervous system drugs for ADHD such as methylphenidate ER (LA), the Michigan Medicaid Clinical and PDL Criteria requires in part:

METHAMPHETAMINE

Requests will require MDHHS review for patient-specific medical necessity according to the following criteria:

INITIAL REQUESTS

- Patient must be 6 years of age or older; **AND**
- Patient has a diagnosis of attention-deficit hyperactivity disorder (ADHD); **AND**
- Prescribed by or in consultation with a psychiatrist; **AND**
- Medical necessity is demonstrated through submission of medical records/documentation that **contains specific documentation of each of the following:**
  - Diagnostic justification for ADHD, including use of standardized criteria; **AND**
  - Patient has tried and failed immediate-release **AND** extended-release methylphenidate; **AND**
  - Patient has tried and failed immediate-release **AND** extended-release amphetamine; **AND**
  - Patient has tried and failed immediate-release **AND** extended-release mixed amphetamine salts (amphetamine/dextroamphetamine); **AND**
  - Patient has tried and failed immediate-release **AND** extended release dextroamphetamine; **AND**
  - Patient has tried and failed immediate-release **AND** extended release dexmethylphenidate; **AND**
  - Patient has tried and failed serdexmethylphenidate/dexmethylphenidate; **AND**

- Patient has tried and failed lisdexamfetamine; **AND**
- Patient has tried and failed atomoxetine; **AND**
- Patient has tried and failed viloxazine; **AND**
- Patient has tried and failed extended-release clonidine; **AND**
- Patient has tried and failed extended release guanfacine; **AND**
- Results of clinical evaluation for stimulant use disorder; **AND**
- Specific justification for use of methamphetamine at the requested dosage, including any relevant dosage titration schedule/plan and accompanying rationale in light of treatment history; **AND**
- Current clinical notes outlining all diagnoses, current medications, description of patient symptoms and treatment plan; **AND**
- Broad panel urine toxicology screening results (within 2 months of request); **AND**
- Detailed description of MAPS review and reconciliation with prescribed drugs and current toxicology screening results . . .

Exhibit A, page 24

Here, Prime Therapeutics, as the contracted agent for MDHHS received a prior authorization request for methylphenidate ER (LA) submitted on Petitioner's behalf by her doctor.

Respondent's representative testified that pursuant to the above criteria, the request could not be approved by Prime Therapeutics because required information was not provided. In particular, she noted that the submitted clinical information did not identify the basis for Petitioner's ADHD diagnosis or what other medications had been ruled out prior to the request for the non-preferred medication in this case.

Respondent's representative also testified that given that finding, Petitioner's request was forwarded to MDHHS for a final determination on whether the clinical criteria had been met. She further testified that the Department physician reviewed the request and determined that it should be denied as it did not meet clinical criteria.

In response, Petitioner argued that she previously received the medication pursuant to her Medicaid plan when she lived in Washington, D.C., and that the denial in this case was an unnecessary lapse in coverage because the Department should have all the necessary records. She also noted that she was subsequently approved for the medication.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying her prior authorization request. Moreover, the undersigned ALJ is limited to reviewing Respondent's decision in light of the information that was available at the time the decision was made.

Given the available information and applicable policies in this case, Petitioner has failed to meet that burden of proof; and the Respondent's decision must be affirmed.

As discussed above, the Department has been authorized by federal law to develop both a formulary of approved prescriptions and a prior authorization process; it has done so; and with respect to prescriptions for central nervous system drugs for ADHD such as methylphenidate ER (LA), it has specific documentation requirements.

With respect to the current request, it is undisputed that the submitted documentation did not meet those requirements with respect to Petitioner's diagnosis or what preferred medications had been ruled out.

Moreover, while Petitioner mistakenly believes that the Department can access her medical file whenever it wants, Respondent's representative credibly explained that neither the Department nor Prime Therapeutics has access to Petitioner's medical file or information, and they must rely on what the doctor submits, which was clearly insufficient in this case.

Additionally, while it is undisputed that Petitioner was subsequently approved for methylphenidate ER (LA) after filing the request for hearing in this case, that does not mean that the denial at issue in this case was improper. Petitioner's doctor submitted additional information along with that new request while the undersigned ALJ is limited to reviewing Respondent's decision in light of the information that was available at the time the decision was made, which, again, was insufficient.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that Respondent properly denied Petitioner's prior authorization request.

IT IS, THEREFORE, ORDERED that:

- Respondent's decision is **AFFIRMED**.

Steven Kibit

STEVEN KIBIT
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to LARA-MOAHR-DCH@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

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