

In the matter of:

<u>Case Number:</u>	<u>County:</u>	
5005399513	HAMILTON	
<u>Appeal:</u>	<u>Program:</u>	<u>Disposition:</u>
1444426	MED	OVERRULED
No Compliance Required		
<u>Decision Date:</u>	03/17/2009	
<u>Request Date:</u>	10/24/2008	
<u>Hearing Officer:</u>	PAUL STANISZEWSKI	

State Hearing Decision

ISSUE (1444426):

Certain prescription drugs require Prior Authorization in order for Medicaid to reimburse, while some scripts may not be reimbursable. The appellant asserts that he should be reimbursed for out-of-pocket costs related to his 2007 Physician #2 and #3 Oxycontin prescriptions.

For the reasons set forth in the State Hearing Decision, I find that he is not eligible to receive reimbursement for the out-of-pocket costs that are related to his 2007 Physician #2 and #3 Oxycontin prescriptions.

Therefore, the appeal is Overruled.

PROCEDURAL MATTERS:

The Hamilton County DJFS mailed the notices to the address of record on 10/01/08. On 10/24/08, the Bureau of State Hearings received the State Hearing request.

The State Hearing was conducted on 03/10/08.

The agency representatives are Lynne Bonner, Ruth Haubner, and Chris Monette, Pharmacist. The appellant and his wife attended the State Hearing.

FINDINGS OF FACT:

1. The appellant is Medicaid eligible and an Amerigroup member.
2. Caremark provides Pharmacy Services to Amerigroup members.
3. On 09/26/07, Caremark received a Prior Authorization request for Oxycontin 40 mg #30 and Oxycontin 20 mg #30 from Physician #1.
4. On 08/14/07, the Prior Authorization from Physician #1 issued for a six (6) month period.
5. On 09/26/07, he submitted the Physician #1 prescriptions to the Pharmacy.
6. The Physician #1 – two (2) 30 day prescriptions were paid for through Caremark member services.

7. The appellant voluntarily chose to seek Oxycontin prescriptions from Physician #2 during the same period.
8. Physician #2 wrote a second script for Oxycontin 40 mg #90 and Oxycontin 20 mg #90.
9. Physician #2 did not submit a Prior Authorization request to Caremark for Oxycontin 40 mg #90 and Oxycontin 20 mg #90.
10. Also on 09/26/07, he submitted the Physician #2 Oxycontin prescriptions to the Pharmacy.
11. The appellant paid out-of-pocket for the Physician #2 Oxycontin prescriptions.
12. The appellant voluntarily chose to seek an Oxycontin prescription from Physician #3 during the same period.
13. Physician #3 wrote a third script for Oxycontin 40 mg #15.
14. Physician #3 did not submit a Prior Authorization request to Caremark for Oxycontin 40 mg #15.
15. On 11/17/07, he submitted the Physician #3 Oxycontin prescription to the Pharmacy.
16. Caremark rejected payment of the Physician #3 Oxycontin 40 mg #15 prescription.
17. The appellant paid out-of-pocket for the Physician #3 Oxycontin prescription.
18. The appellant voluntarily chose to seek an Oxycontin prescription from Physician #4 during the same period.
19. Physician #4 wrote a fourth script for Oxycontin 80 mg #60.
20. Physician #4 submitted a Prior Authorization request to Caremark for Oxycontin 80 mg #60.
21. The Prior Authorization from Physician #4 issued for Oxycontin 80 mg #60.
22. On 11/19/07, he submitted the Physician #4 Oxycontin prescription to the Pharmacy.
23. Caremark member services paid for the Physician #4 Oxycontin 80 mg #60 prescription.
24. Caremark determined that the appellant is not eligible for reimbursement for his out-of-pocket costs related to the Physician #2 and Physician #3 prescriptions.

POLICY:

Ohio Admin. Code §5101:3-1-02 Reimbursement for medicaid covered services [except as provided through medicaid contracting managed care plans (MCPs)]. [2006]

- (A) Most medical procedures are reimbursable within certain administrative limitations; some are reimbursable if approved in advance by the department through prior authorization or pre-certification; and, some are ordinarily not reimbursable.
- (B) The following general principles determine whether a particular medical service is reimbursable:
 - (1) The service is determined to be medically necessary...
 - (2) ...The consumer or authorized representative originates all requests for medicaid services.
 - (3) Services are provided within the limits of the medicaid benefit package, within the scope and practice of the provider as defined by applicable federal, state, and local laws and regulations...
 - (4) ...The consumer selects the eligible provider of his or her choice...

- (5) ...The service is rendered by an eligible provider...
 - (6) ...The consumer makes no payment for medicaid-covered services, except as noted in rule 5101:3-1-13.1...
 - (7) ...The consumer receives medical services at the same cost as or less than non-medicaid individuals...In addition, the department will not pay for services that are charged at a rate greater than the provider's usual and customary charge to other patients...
- (C) The consumer has the right to appeal to the department, in accordance with division-level 5101:6 of the Administrative Code, any decision that adversely affects the consumer...

Ohio Admin. Code §5101:3-1-01 Medicaid: medical necessity. [2006]

- (A) "Medical necessity" is a fundamental concept underlying the Medicaid program. Physicians, dentists, and limited practitioners render, authorize, or prescribe medical services within the scope of their licensure and based on their professional judgment regarding medical services needed by an individual. Unless a more specific definition regarding medical necessity for a particular category of service is included within division-level designation 5101:3 of the Administrative Code, "medically necessary services" are defined as services that are necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. A medically necessary service must:
- (1) Meet generally accepted standards of medical practice;
 - (2) Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome;
 - (3) Be appropriate to the intensity of service and level of setting;
 - (3) Provide unique, essential, and appropriate information when used for diagnostic purposes;
 - (4) Be the lowest cost alternative that effectively addresses and treats the medical problem;
 - (5) Meet general principles regarding reimbursement for Medicaid covered services found in rule 5101:3-1-02 of the Administrative Code.

Ohio Admin. Code §5101:3-1-60.22 Direct reimbursement to medicaid recipients for out-of-pocket payments for medicaid covered services.

- (A) ...In the case of erroneous determinations...ODHS will work with providers who received payment from recipients to facilitate the timely reimbursement of full payment to those recipients by their provider. If the provider does not reimburse the recipient in a timely manner, the department will directly reimburse the recipient of the medicaid

covered service as specified in paragraph (B) of this rule as expeditiously as possible, not to exceed ninety days following completion of all the requirements of this rule...

- (B) ...ODHS will reimburse recipients who meet the conditions specified in paragraph (A) of this rule in the following manner:
- (1) If the recipient obtained the service from a medicaid contracting provider, ODHS will reimburse the recipient's full documented payment.
 - (2) If the recipient obtained the service from a provider who does not contract with medicaid, ODHS will reimburse the lesser of the recipient's payment or an amount equal to the rate medicaid pays medicaid contracting providers for the same service.
- (C) All the provisions set forth in the chapters of agency-level designation 5101:3 of the Administrative Code remain in effect, except that direct reimbursement by ODHS to individual recipients of medicaid covered services is permitted under the circumstances set forth in this rule. All notice and hearing provisions set forth in agency-level designation 5101:6 of the Administrative Code apply to determinations made under this rule, and hearing officers have authority to direct ODHS to make payments in accordance with this rule...

ANALYSIS:

The appellant and his wife assert that they are eligible for reimbursement of the out-of-pocket costs that he made for his 2007 Physician #2 and #3 Oxycontin prescriptions.

The record establishes that he voluntarily chose to seek Oxycontin prescriptions from four (4) different Physicians from 08/01/07 through 11/30/07.

Of the four (4) prescriptions that were submitted for payment to Caremark, one of the 09/26/07 (Physician 2) and the 11/17/07 (Physician #3) prescriptions were not Prior Approved.

The appellant acknowledges that the 09/26/07 and 11/17/07 prescriptions were not Prior Approved.

With regard to the Physician #2 prescription, Caremark calculated that filling the prescription would have violated the FDA guidelines. If the prescription for the additional 90 tablets was approved, it would have equaled dosing of four (4) tablets per day, 120 tablets per month. The FDA dosing guideline is for every twelve (12) hours, which equates to two (2) tablets per day, 60 tablets per month.

With regard to the Physician #3 prescription, the Prescription Profile and Caremark records indicate that he was issued enough tablets in 09/07 to last him until 11/26/07. Thus, filling the prescription would have violated the FDA guidelines.

Caremark determined that he is not eligible for reimbursement for the out-of-pocket costs related to the Physician #2 and #3 prescriptions because they were not Prior

Approved and they were not Medically Necessary.

There was no delay in processing his Medicaid benefit and there was no erroneous determination.

The Medicaid regulations require that Oxycontin prescriptions be Prior Approved.

Here, it is undisputed that the Physician #2 and #3 prescriptions were not Prior Approved.

It is also reasonable for Caremark to assert that the prescriptions are not Medically Necessary because filling the prescriptions would have violated the FDA dosing guidelines.

For the reasons set forth in the State Hearing Decision, I find that he is not eligible to receive reimbursement for the out-of-pocket costs that are related to his 2007 Physician #2 and #3 Oxycontin prescriptions.

Therefore, the appeal is Overruled.

HEARING OFFICER'S RECOMMENDATIONS:

Issue (1444426)

The appeal should be Overruled. The Caremark determinations are affirmed.

**OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
BUREAU OF STATE HEARINGS
FINAL ADMINISTRATIVE DECISION AND ORDER:**

The Hearing Officer's recommendation is adopted.

Issue (1444426)

The appeal is Overruled. No orders of compliance shall be issued against the agency based on this appeal.

Hearing Authority

March 17, 2009

Notice to Appellant

This is the official report of your hearing and is to inform you of the decision and order in your case. All papers and materials introduced at the hearing or otherwise filed in the proceeding make up the hearing record. The hearing record will be maintained by the Ohio Department of Job and Family Services. If you would like a copy of the official record, please telephone the hearing supervisor at the CINCINNATI District hearing section at 1-866-635-3748.

If you believe this state hearing decision is wrong, you may request an administrative appeal by writing to: Ohio Department of Job and Family Services, Bureau of State Hearings, P.O.BOX 182825, Columbus, OH 43218-2825 or fax: (614) 728-9574. Your request should include a copy of this hearing decision and an explanation of why you think it is wrong. Your written request must be received by the Bureau of State Hearings within 15 calendar days from the date this decision is issued. *(If the 15th day falls on a weekend or holiday, this deadline is extended to the next work day.)* During the 15-day administrative appeal period you may request a free copy of the tape recording of the hearing by contacting the district hearings section.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free, at 1-800-589-5888, for the local number.

Aviso a la Apelante

Esta es la decisión estatal administrativa de su caso. Todos los documentos y materiales presentados como prueba en la vista o de otra manera radicados componen el récord administrativo. El récord administrativo será mantenido por el Ohio Department of Job and Family Services.

Si usted cree que esta decisión estatal administrativa es errónea, usted puede solicitar una apelación administrativa escribiendo al: Ohio Department of Job and Family Services, Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825 o facsímil (614) 728-9574. Su solicitud debe indicar por qué usted piensa que la decisión administrativa es errónea. Usted puede completar la solicitud de apelación incluida con esta decisión. Su solicitud escrita o formulario de apelación tiene que ser recibido por el Bureau of State Hearings dentro de los 15 días calendario desde la fecha en que esta decisión es expedida. (Si el 15to. día recae sobre un fin de semana o un día feriado, esta fecha límite es extendida al próximo día laborable). Durante el período de 15 días de apelación administrativa, usted o su representante pueden solicitar una copia gratuita del récord administrativo y de la grabación de la vista llamando al Bureau of State Hearings al 1-866-635-3748 (seleccione la opción 1 del menú principal).

Si usted quiere información sobre servicios legales gratuitos pero no sabe el número de su oficina local de servicios legales, usted puede llamar al Ohio State Legal Services Association, gratuitamente, al 1-800-589-5888, para el número local.

STATE HEARING DECISION CONTINUATION

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Appendix

AGENCY EXHIBITS:

- A. Appeal Summary (3 p)
- B. 07/25/01 and 01/15/09 Oxycontin Articles (4 p)
- C. Carmark Prescription Drug Claim Forms with verifications (7 p)

APPELLANT EXHIBITS:

- 1. State Hearing Request (1 p)
- 2. Explanation of Benefits and Prescription Profile (10 p)