STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3725

[redacted] **2025**
SIGNATURE CONFIRMATION

Case ID # [redacted]
Client ID # [redacted]
REQUEST #253722

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2024, the Department of Social Services (the "Department") denied a claim for a refill of Mounjaro for [redacted] (the "Appellant") because it requires an early refill Prior Authorization ("PA") because it was less 28 days since the prior refill.

On [redacted] 2024, the Appellant requested an administrative hearing to contest the Department's denial of her prescription medication.

On [redacted], 2025, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling an administrative hearing for [redacted], 2025.

On [redacted] 2025, in accordance with sections 17b-60, 17-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing.

On [redacted] 2025, in accordance with sections 17b-60, 17-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH reconvened the administrative hearing

The following individuals were present at the hearing:

[redacted], the Appellant
[redacted], Counsel for the Appellant
[redacted], Co-Counsel for the Appellant
Cynthia Cartier, Staff Counsel, OLCRAH, Department of Social Services
Jason Gott, Pharmacy Consultant, Representative for the Department

Herman Kranc, Pharmacy Manager, for the Department
Scott Zuckerman, Hearing Officer

At the end of the hearing on [redacted], 2025, the Department's counsel requested a reconvene of the hearing to allow time to subpoena the records and the pharmacist at CVS.

On [redacted] 2025, OLCRAH reconvened the administrative hearing originally held on [redacted] 2025.

At the end of the hearing, the record was left open to allow the parties to submit post-hearing briefs and for OLCRAH to prepare audio of the administrative hearing per counsel's request.

The Hearing Officer granted the request and gave the Appellant's counsel until [redacted] 2025, to file the post-hearing brief.

The Hearing Officer gave the Department ten days to respond to the Appellant's post-hearing brief and pursuant to the Appellant's counsel's request, gave the Appellant seven business days to respond to the Department's reply brief.

On [redacted] 2025, the Appellant's counsel filed a post-hearing reply brief and the hearing record was closed on [redacted], 2025.

A separate hearing decision will be issued to address the Department's proposal to deny the prescription drug Zepbound for weight loss.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department rendered a decision adversely affecting the Appellant's participation in the Medicaid program or her entitlement to the prescription drug, Mounjaro.

FINDINGS OF FACT

1. The Appellant is a recipient of medical assistance under the Medicaid program, which provides payment for Pharmaceutical services subject to conditions and limitations. (Hearing Record)

2. In [redacted]l 2024, the Appellant's physician, Dr. [redacted] prescribed Mounjaro, a prescription drug approved by the FDA for diabetes but also used to assist in weight loss. The Appellant had a BMI of well over 35 and has been able to keep her weight manageable while on the medication. (Appellant's testimony and Exhibit I, Letter from [redacted]/2025)

3. On [redacted], 2024, CVS Pharmacy submitted a claim identified by Internal Control Number ("ICN") [redacted] and was reimbursed by the Department for a 28-day supply of Mounjaro for the Appellant, a prescription drug used to help lower blood sugar

levels in people with type 2 diabetes. The drug also assists in weight loss for adults. (Hearing Record, Ex. 5: Claims Search)

4. On [redacted], 2024, the Department's Medical Assistance Program, issued a Policy Transmittal 2024-30 / Provider Bulletin ("PB") 2024-66 [redacted] 2024. The Bulletin was issued to Pharmacies, Physicians, Nurse Practitioners, Clinics, and Hospitals regarding a diagnosis requirement of Type 2 diabetes for GLP – 1 Agonist Medications. (Exhibit A: Provider Bulletin 2024 –[redacted] 2024)

5. *Effective* [redacted] *2024, members who have been prescribed GLP-1 medications in the past for indications other than Type 2 diabetes will also require a diagnosis be submitted on the claim but will continue to pay through* [redacted] *2025, regardless of the diagnosis submitted on the claim. The time will allow the prescriber to transition the member to an appropriate therapy when treating conditions other than Type 2 diabetes. Effective* [redacted]*, 2025, all GLP–1 medication pharmacy claims will require an approved Type 2 diabetes diagnosis code. The GLP–1 medications described are only approved for the treatment of Type 2 diabetes per manufacturer prescribing guidelines as well as FDA approval status.* The medications included Trulicity, Byetta, Bydureion, Rybelsus, Victozza/liraglutide, Ozempic, and Mounjaro. (Exhibit A)

6. On [redacted], 2024, the Appellant contacted CVS to check if Mounjaro was available as it is sometimes low in stock. The Appellant sometimes calls other pharmacies in the area to make sure it would be available. (Appellant's testimony)

7. On [redacted], 2024, CVS pharmacy submitted a claim for the Appellant, identified by ICN [redacted] for a supply of Mounjaro. The Department denied the claim error code 7003 – Claim generated alert that requires early refill prior authorization ("PA"). The next refill would not be available to the Appellant until [redacted] 2024, without an early refill PA. The pharmacy did not provide a reason to the Appellant as to why the claim was denied. (Hearing Record, Ex 5: Claims Search)

8. On [redacted] 2024, the Department updated PB 2024-66 to reflect new information. The updated bulletin provided instructions to the pharmacist to provide a flyer to the client when a medication is denied. The Department extended the date for an approved diagnosis to be submitted for a pharmacy claim for members who have been prescribed GLP-1 medications in the past for indications other than Type 2 diabetes. Claims will now continue to be paid through [redacted], 2025. (Exhibit B: Updated PB 2024-66, [redacted]/24)

9. The Department requires an early refill PA when a recipient has consumed less than 93% of the latest refill prescription, which would allow the Appellant to refill the Mounjaro on [redacted] 2024, after the [redacted] 2024, refill. (Hearing Record, Department's testimony, and Ex. 5: Claims search)

10. The Appellant's physician did not submit an early refill PA to obtain Mounjaro earlier than [redacted], 2024. (Department's Testimony)

11. On [redacted], 2024, the Appellant inquired about obtaining a refill for her Mounjaro.

The pharmacy informed her that Mounjaro was no longer covered for weight loss and indicated she needed a Diagnosis of Type II diabetes. The Appellant contacted Walgreens in Branford and CVS and was informed that Medicaid no longer covers Mounjaro for weight loss. (Appellant's testimony and Exhibit J: Screenshot / Call to CVS, [redacted]/24 and Exhibit K: Screenshot / Call to Walgreens, [redacted]24)

12. The Department's updated [redacted], 2024, bulletin to pharmacies advised that claims would continue to be paid for members who were previously prescribed GLP-1 medications for weight loss through [redacted] 2025. (Hearing Record)

13. On [redacted], 2024, the Department's pharmacy unit, after speaking with the Appellant, contacted CVS pharmacy and advised them that the Mounjaro prescription should be refilled. (Hearing Summary)

14. On [redacted] 2024, the Appellant requested an administrative hearing for the denial of Mounjaro. (Hearing Record)

15. On [redacted] 2025, the Department approved a claim (ICN [redacted]) submitted by CVS, for a 28–day supply of Mounjaro per the Appellant's request. (Hearing Record and Exhibit 5)

16. On [redacted] 2025, the Department contacted CVS who confirmed the Appellant received her Mounjaro refill approved on [redacted] 2025. (Hearing Record)

17. There is no evidence that the Appellant requested a refill until [redacted] 2025, when the Appellant received a 28-day supply of Mounjaro. (Department's Testimony and Exhibit 5)

18. The Appellant's testimony is not clear if she was provided a denial notice for a denial of Mounjaro due to not having a diagnosis of Type 2 diabetes while at the CVS pharmacy between [redacted], 2025, and [redacted], 2025. There were no denied claims by the Department for this reason. (Appellant's testimony and Exhibit 5)

19. On [redacted] 2025, the Department updated PB 2024-66. The Department extended the date for an approved diagnosis to be submitted on a pharmacy claim for members who have been prescribed GLP-1 medications in the past for indications other than Type 2 diabetes. The Department indicated it would continue to pay claims through [redacted] 2025. (Exhibit C: Updated PB 2024-66)

20. The Department has not made a decision that adversely affected the Appellant's participation in the Medicaid program or her entitlement to the prescription drug Mounjaro. (Hearing Record)

21. The factors that led to the Appellant's request for an administrative hearing for the denial of Mounjaro, no longer exist. (Hearing Record)

22. The Department does not have jurisdiction to rule on the point at issue in this case, because the matter has been resolved. (Hearing Record)

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes authorizes the Commissioner of Social Services to administer the Medicaid program.

2. 17b-60 of the Connecticut General Statutes provides that an aggrieved person authorized by law to request a fair hearing on a decision of the Commissioner of Social Services or the conservator of any such person on his behalf may make application for such hearing in writing over his signature to the commissioner and shall state in such application in simple language the reasons why he claims to be aggrieved. Such application shall be mailed to the commissioner within sixty days after the rendition of such decision. The commissioner shall thereupon hold a fair hearing within thirty days from receipt thereof and shall, at least ten days prior to the date of such hearing, mail a notice, giving the time and place thereof, to such aggrieved person, or if the application concerns a denial of or failure to provide emergency housing, the commissioner shall hold a fair hearing within four business days from receipt thereof, and shall make all reasonable efforts to provide notice of the time and place of the fair hearing to such aggrieved person at least one business day prior to said hearing. A reasonable period of continuance may be granted for good cause. The aggrieved person shall appear personally at the hearing, unless his physical or mental condition precludes appearing in person, and may be represented by an attorney or other authorized representative. A stenographic or mechanical record shall be made of each hearing, but need not be transcribed except (1) in the event of an appeal from the decision of the hearing officer or (2) if a copy is requested by the aggrieved person, in either of which cases it shall be furnished by the Commissioner of Social Services without charge.

3. Section 17b-278L of the Connecticut General Statutes provides for medical assistance for obesity treatment, surgery Definitions and State Plan amendments.

   (a)(1) As used in this section, “bariatric surgery” means surgical changes to the digestive system to help a patient with obesity to lose weight;

   (2) “Body mass index” means the number calculated by dividing an individual's weight in kilograms by the individual's height in meters squared;

   (3) “Medical services” means (A) prescription drugs approved by the federal Food and Drug Administration for the treatment of obesity on an outpatient basis, and (B) nutritional counseling provided by a registered dietitian-nutritionist certified pursuant to section 20-206n;

   (4) “Severe obesity” means a body mass index that is:(A) Greater than forty; or (B) Thirty-five or more if an individual has been diagnosed with a comorbid disease or condition, including, but not limited to, a cardiopulmonary condition, diabetes, hypertension or sleep apnea; and

   (5) “Obesity” means a body mass index of thirty or higher.

   (b) The Commissioner of Social Services shall provide medical assistance for (1) bariatric surgery and related medical services for Medicaid and HUSKY B beneficiaries

with severe obesity, and (2) medical services for Medicaid and HUSKY B beneficiaries with a body mass index greater than thirty-five, provided such beneficiaries otherwise meet conditions set by the Centers for Medicare and Medicaid Services for such surgery and medical services. If necessary, the commissioner may amend the Medicaid state plan and the state plan for the Children's Health Insurance Program to implement the provisions of this section.

4. Connecticut General Statutes §17b-491a(a) provides that the Commissioner of Social Services may require prior authorization of any prescription for a drug covered under a medical assistance program administered by the Department of Social Services, including an over-the-counter drug. The authorization for a brand name drug product shall be valid for one year from the date the prescription is first filled. The Commissioner of Social Services shall establish a procedure by which prior authorization under this subsection shall be obtained from an independent pharmacy consultant acting on behalf of the Department of Social Services, under an administrative only contract.

5. Medical Services Policy Section 174 provides that the drug program provides Medicaid reimbursement for accepted methods of drug treatment for Title XIX patients.

    A. Provides definitions as follows:

        XVII "Pharmacy" means a facility licensed by the Commission of Pharmacy in the Department of Consumer Protection under Section 20-168 of the Connecticut General Statutes or by the appropriate regulatory body of the state in which it is located.

        XIX "Prescription" means an order issued by a licensed authorized practitioner and documented in writing by either the practitioner or pharmacist. In nursing homes the signed order of a licensed authorized practitioner will be accepted in lieu of a written or oral prescription. The written prescription includes:

            a. the name and address of the patient; and
            b. whether the patient is an adult or a child, or the patient's specific age; and
            c. the compound or preparation ordered; and
            d. its strength when applicable and the specific amount thereof, to be dispensed at one time; and
            e. directions for the use of the medication and any cautionary statements required; and
            f. the number of times that the prescription may be refilled, if applicable; and
            g. date of issuance; and
            h. name and address of the prescribing practitioner and his/her Drug Enforcement Act number when appropriate

6. Medical Services Policy Section 174C provides that eligibility for payment for Pharmaceutical Services is available for all Medicaid eligible recipients subject to the conditions and limitations which apply to these services.

7. Medical Services Policy Section 174D provides for covered services and limitations as follows:

    I. Services Covered

    Except for the limitations and exclusions listed below, the Department will pay for drugs which are prescribed by a licensed authorized practitioner as a result of accepted methods of diagnosis and treatment.

    II. Service Limitations

    a. Maximum Allowable Supply

    The Department will not reimburse for an original prescription or refill that exceeds the supply requirement for a period of thirty (30) days not to exceed two hundred and forty (240) units except in the following instances:

    1. Prescriptions for chronic conditions or maintenance drugs shall be for at least a thirty (30) day supply not to exceed two hundred and forty (240) units unless a lesser amount is prescribed.

The availability and supply of the prescription drug, Mounjaro, provided to the Appellant under the Medicaid program have not been changed by the Department as of the date of her hearing request and hearing as there were no changes for existing prescriptions.

CVS Pharmacy incorrectly informed the Appellant that she was not eligible for a refill of Mounjaro on or after [redacted], 2024, however, the matter was rectified and she received her 28-day supply on [redacted] 2025.

8. "The Department's uniform policy manual is the equivalent of a state regulation and, as such, carries the force of law." Bucchere vs. Rowe, 43 Conn. Supp. 175,178 (1994) (citing Conn. Gen. Stat § 17b-10; Richard v. Commissioner of Income Maintenance, 214 Conn. 601,573 A.2d 712 (1990)).

9. Uniform Policy Manual ("UPM") § 1570.25 (C)(2)(k) provides that the Fair Hearing Official renders a Fair Hearing decision in the name of the Department, in accordance with the Department's policies and regulations. The Fair Hearing decision is intended to resolve the dispute.

    UPM § 1570.25(F)(1)(c) provides that the Department must consider several types of issues at an administrative hearing, including the following: discontinuance, termination, or reduction of benefits.

The Appellant's appeal regarding the denial of Mounjaro, to treat her weight loss for the reason of early refill is hereby dismissed as moot, as the matter had been resolved. There is no relief that could be provided. The Appellant received her medication when it was available for a refill. There was no evidence provided that the Appellant was denied a claim for the reason that she must have an alternate diagnosis of Type 2 diabetes and subsequently denied. On [redacted] 2025, the Department correctly approved her claim for a 28-day supply of Mounjaro.

The Appellant's hearing issue has been resolved, therefore, there is no issue on which to rule. "When the actions of the parties themselves cause a settling of their differences, a case becomes moot." McDonnell v. Maher, 3 Conn. App. 336 (Conn. App. 1985), citing, Heitmuller v. Stokes, 256 U.S. 359, 362-3, 41 S.Ct. 522, 523-24, 65 L.Ed. 990 (1921). The medication that the Appellant had originally requested to refill on [redacted] 2024, has been approved; there is no practical relief that can be afforded through an administrative hearing decision.

DECISION

The Appellant's appeal is **DISMISSED as MOOT.**

DISCUSSION

The Appellant's argument at the administrative hearing that the Mounjaro may be discontinued at some time in the future, is irrelevant, to the issue of this hearing request, which is the denial of Mounjaro due to an early refill. As of the date of the hearing, the Appellant's Mounjaro continues to be refilled monthly. Should the Appellant's monthly refill of Mounjaro be discontinued, the Appellant may submit a request for an administrative hearing for the discontinuance of said medication. The Appellant requests that she should receive a retroactive supply of Mounjaro from [redacted] 2024, through [redacted] 2025, the date the claim was approved. The Appellant's claim was denied for an early refill on [redacted] 2024. There were no other claims issued for Mounjaro until the prescription was filled and paid for by the Department on [redacted] 2025.

Scott Zuckerman
Scott Zuckerman
Hearing Officer

Pc: Herman Kranc, Medical Care Administration, DSS,
Jason Gott, Medical Care Administration, DSS
Cynthia Cartier, Staff Attorney, DSS
Sheldon Toubman, Disability Rights Connecticut

RIGHT TO REQUEST RECONSIDERATION

The appellant has the right to file a written reconsideration request within **15** days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within **25** days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on § 4-181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Administrative Hearings and Appeals, 55 Farmington Avenue Hartford, CT 06105.

RIGHT TO APPEAL

The appellant has the right to appeal this decision to Superior Court within **45** days of the mailing of this decision, or **45** days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on § 4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 165 Capitol Avenue, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or the Commissioner's designee in accordance with § 17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the appellant resides.