**STATE OF MICHIGAN**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES**
**FOR THE DEPARTMENT OF COMMUNITY HEALTH**
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2009-17669 QHP
Case No. [redacted]
Load No. [redacted]

## 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 hearing was held on [redacted]. [redacted] for clinical appeals represented [redacted], (hereinafter Medicaid Health Plan or MHP). [redacted] also appeared on behalf of the Medicaid Health Plan.

[redacted] represented herself at hearing.

## ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for breast reduction surgery?

## FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. Appellant is a Medicaid beneficiary who is currently enrolled in [redacted], a Medicaid Health Plan (MHP).

2. The Appellant is a [redacted] female with 2 young children. She is [redacted] tall and weighs [redacted]. Her BMI is [redacted].

3. The Appellant's medical conditions include chronic back, neck and shoulder pain caused by breast deformity. Her breast size is [redacted]. She requires customized bras costing $[redacted] each to accommodate her breast size.

4. The Appellant is unemployed.

5. The Appellant receives cash assistance from the Family Independence program for herself and her two children. She is excused from participation in work related activities due to her medical condition.

6. The Appellant's pain is not well controlled with medications or any conservative medical treatment documented in her medical records.

7. The Appellant is unable to attend to her children's needs at times due to the pain she experiences in her back, neck and shoulders. The Appellant does not get out of bed sometimes due to the debilitating pain.

8. On [redacted], the MHP received a prior authorization request from [redacted], requesting coverage for Reduction Mammoplasty (bilateral breast reduction) for the Appellant. The documentation received at the time of the request included a letter of request, a short progress note from [redacted] and photographs of the Appellant. *(Exhibit A)*

9. On [redacted], the MHP denied the request after consulting their own internal criteria for breast reduction.

10. On [redacted], the Appellant submitted her Request for Hearing to the State Office of Administrative Hearings and Rules for the Department of Community Health.

## 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 Medicaid Health Plans.

[redacted] Health Plan is one of those Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverage(s) 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 1-Z.

Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, September 30, 2004.

The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.

- An annual review and reporting of utilization review activities and outcomes/interventions from the review.

The Contractor must establish and use a written prior approval policy and procedure for utilization management 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 utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Article II-P, Utilization Management, Contract, September 30, 2004.

Under its contract with the Department, an MHP may devise criterion for coverage of medically necessary services, as long as those criterion do not effectively avoid providing medically necessary services. An MHP must also provide its members with the same or similar services and/or medical equipment to which fee-for-service beneficiaries would otherwise be entitled under the Medicaid Provider Manual.

Reduction Mammoplasty falls within Medicaid Provider Manual policy governing cosmetic procedures. Cosmetic surgery is a Medicaid covered service, given the following articulated conditions.

**13.2 COSMETIC SURGERY**

Medicaid only covers cosmetic surgery if PA has been obtained. The physician may request PA if any of the following exist:

- The condition interferes with employment.
- It causes significant disability or psychological trauma (as documented by psychiatric evaluation).
- It is a component of a program of reconstructive surgery for congenital deformity or trauma.
- It contributes to a major health problem.

The physician must identify the specific reasons any of the above criteria are met in the PA request.

*Michigan Department of Community Health*
*Medicaid Provider Manual; Practitioner*
*Version Date: April 1, 2009*
*Page 64*

The Appellant provided uncontested, credible evidence she is excused from work participation activities due to her debilitating pain. The pain is caused by her deformed breast size, which is so far outside the normal size for breasts she is unable to purchase a bra at the store. She must have them custom made at the cost of [redacted] each. The Appellant's breast size is estimated to exceed [redacted], according to the uncontested medical documentation.

The MHP witnesses provided credible evidence that its denial of Reduction Mammoplasty is predicated upon the fact the Appellant's BMI exceeds their own internal guidelines for the requested surgery. The Appellant did not contest the assertion she has a BMI of [redacted] or that she has not lost weight recently.

This ALJ will apply the criteria set forth in the Medicaid Provider Manual with respect to breast reduction surgery. It is the criteria that would apply if the Appellant were not in a Medicaid Health Plan. The criteria does not require a Medicaid beneficiary to have a BMI less than 35 in order to qualify for surgery. Applying the criteria in the Medicaid Provider Manual, there is credible evidenced the Appellant qualifies for the surgery. There is uncontested evidence her breast size interferes with employment. She is unable to even participate in employment seeking activities mandated by federal law (Welfare reform law and policy) due to her condition. Additionally, her breasts are a deformity at their current size. There is sufficient evidence in the record to find that but for her BMI she would have been approved for the surgery. The requirement that her BMI be less than 35 in order to qualify for surgery is more restrictive than the criteria set forth in the Medicaid Provider Manual. This ALJ cannot rely on that criteria to uphold the MHP's denial. The Appellant has presented sufficient credible evidence of the medical necessity for this procedure.

## DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I find the Appellant has established, by a preponderance of the evidence presented, that her request for Reduction Mammoplasty is medically necessary.

**IT IS THEREFORE ORDERED** that:

The Medicaid Health Plan's decision is REVERSED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/22/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 State Office of Administrative Hearings and Rules for the Department of Community Health 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 mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.