STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

Appellant
_____________________/

Docket No. 2009-19970 QHP
Case No.

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9; MSA 16.409 and MCL 400.37; MSA 16.437, following the Appellant's request for a hearing.

After due notice, hearings were held on Appellant) appeared and testified on her own behalf at all hearings.

, appeared on behalf of a Medicaid Health Plan (MHP).

The , hearing commenced as scheduled. Exhibits 1 and 2 were admitted at that time. Following the presentation of proofs, the Appellant requested a continuation of the hearing in order to gather additional medical documentation. At that time, she waived the 90-day federal timeliness requirement on the record.

At the onset of the hearing, the Appellant again requested a continuation of the hearing, claiming she was experiencing difficulty obtaining documentation in support of her appeal. The hearing was continued to

The , commenced as scheduled. At that time, the MHP indicated it has received additional medical documentation which was not in the hearing file as of that date. Following the conclusion of the hearing, the documentation was faxed to the State Office of Administrative Hearings and Rules (SOAHR); it was made part of Exhibit 1.

ISSUE

1. Has the MHP appropriately denied the Appellant's prior authorization request for a Panniculectomy?

FINDINGS OF FACT

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

1. Appellant is a female Medicaid beneficiary, and presently enrolled with , a Medicaid Health Plan. In the Appellant underwent gastric bypass surgery, and has lost in excess of 250 lbs since that time. As a result of the significant weight loss, the Appellant retains a significant amount of excess skin. *(Testimony of Appellant)*

2. On the Appellant requested prior authorization coverage for a panniculectomy, claiming the excess skin caused chronic skin irritation due to rubbing and chafing.

3. On , the MHP denied coverage based on failure to satisfy coverage criteria. The MHP covers this procedure when there is medical documentation establishing the panniculus caused chronic intertrigo (dermatitis occurring on opposed surfaces of the skin, skin irritation, infection or chafing) that consistently recurs over 6 months while receiving appropriate medical therapy, or remains refractory to appropriate medical therapy over a period of six months. *(Exhibit 1; p. 1)*

4. On , the Appellant filed her request for hearing with SOAHR.

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.

The Respondent 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 coverage(s) 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.

Fee-for-service Medicaid beneficiaries are subject to the prior approval process found in the Medicaid Provider Manual. MHPs may also subject its beneficiaries to the prior approval process; however, the MHP must bear in mind that its beneficiaries are entitled to the same benefits as fee-for-service Medicaid beneficiaries.

Both procedures requested in this matter would be evaluated under general Cosmetic Surgery policy found in the Medicaid Provider Manual. MHP beneficiaries need only satisfy one of the criteria referenced below in order to qualify for coverage.

The MHP argues the Health Member Handbook and Certificate of Coverage govern coverage for either procedure. This argument is afforded limited merit. Coverage decisions rendered in accordance with an MHP's Certificate of Coverage, regardless of approval by another State Administrative Agency, such as the Office of Financial and Insurance Regulation (OFIR), will be upheld, but only to the extent the decision is not based upon policy deemed more restrictive in nature than coverage for cosmetic surgical procedures found in the Medicaid Provider Manual.

Cosmetic surgical procedures are a covered service for non-Medicaid Health Plan beneficiaries under the following provisions:

<u>Prior Authorization Standard Language</u>

Cosmetic Surgery (Breast Reduction and Panniculectomy/Abdominoplasty)

Medicaid only covers cosmetic surgery if prior authorization has been obtained. The physician may request prior authorization if any of the following conditions 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;
- contributes to a major health problem.

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

Medicaid Provider Manual; Practitioner; Version Date: January 1, 2008, page 64

A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. See, e.g., *J.K By and Through R.K. v Dillenberg*, 836 F Supp 694, 700 (Ariz, 1993). Whether the Appellant satisfied her burden here must be determined in accord with the preponderance of the evidence standard. See, e.g., *Aquilina v General Motors Corp*, 403 Mich 206, 210; 267 NW2d 923 (1978).

Regarding an appeal filed with the State Office of Administrative Hearing and Rules for the Department of Community Health, the Administrative Law Judge is given ultimate discretion to determine the weight and credibility of the evidence presented. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996) (the fact finder is provided with the unique opportunity to observe or listen to witnesses; and, it is the fact finder's responsibility to determine the credibility and weight of the testimony and other evidence provided).

Thus, the Appellant bears the burden of establishing the MHP has denied a medically necessary service, as established through both testimonial and documentary evidence.

Here, the Appellant was given numerous opportunities to provide the MHP and SOAHR with medical documentation specifically addressing the claim that the excess skin caused significant disability or contributes to major health problems. The medical documentation provided, however, addresses a number of other health concerns, including cardiac laboratory testing results, shoulder pain, etc. The only indicator of a potential problem related to excess skin is the mention of a boil occurring in the Appellant’s private area. While certainly a condition that must be treated, the existence of a boil does not, in and of itself, establish, by a preponderance of the evidence, that the Appellant’s excess skin causes significant disability or contributes to a major health problem.

The Appellant also claims that her excess skin causes pain and discomfort while ambulating. Although the medical documentation makes mention of a prescription for pain medications, it otherwise fails to contain any indication of the source of such pain, and/or whether the pain is directly associated with the excess skin issue.

The MHP witness indicated that the requested procedure was denied because there was no medical documentation establishing its criteria, as articulated under Finding of Fact #2, was satisfied.

Although the MHP’s criterion is different than that found in the Medicaid Provider Manual, I nonetheless conclude it is consistent with cosmetic surgery policy, because chronic infection, one of the articulated coverage criteria, frequently contributes to major health problems.

Based on the medical evidence presented, I therefore conclude the Appellant fails to satisfy Medicaid Provider Manual criteria for a panniculectomy, rendering appropriate the MHP’s denial of coverage.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the MHP's denial of Appellant's request for Panniculectomy is proper, as in accord with Medicaid policy and its contract with the Department regarding this procedure.

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: 9/15/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 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.