STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2010-13179 QHP
[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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared on her own behalf.

[redacted] was represented by [redacted], Director of Customer and Provider Services. [redacted], Nurse Case Manger, appeared as a witness for [redacted]. [redacted] is a Department of Community Health contracted Medicaid Health Plan (hereinafter MHP).

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for a panniculectomy and abdominoplasty?

FINDINGS OF FACT

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

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

2. The Appellant underwent gastric bypass surgery in [redacted] and has lost a significant amount of weight. However, she now has excessive skin and fat of the lower abdomen. (Exhibit 1, page 6)

3. On [redacted], the MHP received a prior authorization request for panniculectomy and abdominoplasty from the Appellant's doctor with an attached office note. (Exhibit 1 pages 5-6)

4. On [redacted], the MHP sent the Appellant a letter notifying her that the request for panniculectomy and abdominoplasty was not authorized because the submitted clinical documentation did not document ulcerations or infections unresponsive to at least 6 months of treatment or contain photographs of ulcerations or rashes that are untreatable with medications or conservative measures. Accordingly, the documentation submitted did not support the medical criteria for the procedure. (Exhibit 1 page 12)

5. On [redacted], the Appellant filed a request for hearing contesting the MHP denial for panniculectomy and abdominoplasty.

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 coverages 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.*

Panniculectomy and abdominoplasty surgery falls within Medicaid Provider Manual policy governing general surgery. Section 12 General Surgery states "Medicaid covers medically necessary surgical procedures." *Michigan Department of Community Health Medicaid Provider Manual; Practitioner Version Date: October 1, 2009, Page 60.*

The Appellant has a history of successful gastric bypass surgery in [redacted] The Appellant lost a significant amount of weight; however, she now has an excessive skin and fat of the lower abdomen. (Exhibit 1 page 6) According to the [redacted] office note, her physician documented complaints of sweating, infection and low back pain due to the excess lower abdominal skin and fat. (Exhibit 1, page 6)

As stated in the contract language above, MHP coverages and limitations must be consistent with Medicaid policy. The MHP testified that the criteria used for considering

panniculectomy and abdominoplasty surgery were consistent with Medicaid policy. The MHP said it based its decision on medical necessity, which is consistent with Medicaid policy.

The above contract language also says an MHP must conform to managed health care industry standards and processes and its utilization management decisions must be made by a health care professional who has appropriate clinical expertise regarding the service under review. The MHP physician reviewers have appropriate clinical expertise for surgical procedures regarding the Appellant. The MHP submitted the Apollo Medical Review Criteria Guidelines for Managed Care and the Michigan Association of Health Plans (MAHP) Guidelines for Panniculectomy/Abdominoplasy. (Exhibit 1, pages 8-9) The MHP testified the guidelines are industry standards and are used by the MHP to determine medical necessity. The MHP testified that the Apollo Criteria and MAHP Guidelines were applied to the medical documentation from the Appellant's physician and it was determined that the Appellant did not meet the criteria guideline or medical necessity.

Specifically the MHP stated that the clinical documentation submitted by the Appellant's physician did not did not document ulcerations or infections unresponsive to at least 6 months of treatment or contain photographs of ulcerations or rashes that are untreatable with medications or conservative measures. (Exhibit 1, page 12) While there is an office note documenting complaints of sweating, infections and low back pain, there is no indication of what conservative medical treatments have been tried, the Appellant's response to these attempts and over what period of time these measures were tried. (Exhibit 1, page 6)

The Appellant testified that she believed the tummy tuck surgery was included with the [redacted] gastric bypass surgery. While that may have been part of the treatment plan with her surgeon, there is no provision to Medicaid policy that supports the Appellant's position that the tummy tuck surgery was included as part of the [redacted] gastric bypass approval.

The Appellant also testified that she has had recurrent infections and rashes for more than 6 months despite treatment attempts. However, because she has not had medical insurance for the several periods since her [redacted] gastric bypass surgery, the Appellant stated she was not always able to see a doctor. Accordingly, the Appellant explained that she attempted to treat these conditions as best she could without prescriptions from doctors during the periods she did not have medical insurance. The Appellant most recently regained medical coverage effective [redacted]. (Exhibit 1, page 2) The Appellant testified that since regaining medical coverage, she has been treated by a doctor for the infections and rashes. The MHP testified that they requested these records, however Appellant's current doctor did not respond to the request.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. *See 42 CFR 440.230.* Medical necessity for a panniculectomy and abdominoplasty can not be established in the Appellant's case without clear clinical documentation of the complications resulting from the excess abdominal skin and fat as

well as the Appellant's response to medications and other conservative treatment measures. Therefore, the MHP properly denied the request.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for panniculectomy and abdominoplasty.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/24/2010

***** 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 receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.