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

Docket No. 2010-32868 QHP
Case No. [redacted]

[redacted],

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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]. The Appellant, [redacted], appeared on her own behalf. Her ex-husband, [redacted], appeared as her witness. [redacted], Director of Member Services, represented the [redacted] of Michigan, Inc., the Medicaid Health Plan (MHP). [redacted], Manager of Patient Services, and [redacted], Medical Director, appeared as witnesses for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for reduction mammoplasty (breast- reduction surgery)?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] year-old female Medicaid beneficiary who is currently enrolled in the Respondent MHP, [redacted] of Michigan, Inc.

2. In [redacted], the MHP received a request for breast-reduction surgery from the Appellant's physician. The Appellant's physician noted that more than 600 grams of tissue would be removed from each breast and that the surgery would improve the Appellant's ability to participate in normal daily activities. (Exhibit 1, pages 9-11)

3. On [redacted] the MHP sent the Appellant a denial notice, stating that her request for breast-reduction surgery was not authorized because the submitted clinical documentation did not establish that all criteria for the procedure had been met. Specifically, there was no documentation of a six-month trial and failure of at least two conservative treatments for back /neck

pain; there was no documentation of severe shoulder grooving; and there was no documentation of skin irritation along the breast or chest wall. (Exhibit 1, pages 13-16)

4. The Appellant requested a formal, administrative hearing contesting the denial on [redacted]. (Exhibit 1, page 7)

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 MHPs.

The Respondent is one of those MHPs.

> 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. The Contractor 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 2.024.
>
> *Section 1.022(E)(1), Covered Services.*
> *MDCH contract (Contract) with the Medicaid Health Plans,*
> *October 1, 2009.*

> (1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

(a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.

(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.

(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.

(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.

(e) The Um activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure
The Contractor must establish and use a written prior approval policy and procedure for UM 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Section 1.022(AA), Utilization Management, Contract, October 1, 2009.

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 or medical equipment to which fee-for-service beneficiaries would otherwise be entitled under the Medicaid Provider Manual.

Fee for Service Medicaid beneficiaries have limited access to cosmetic surgical procedures. Reduction mammoplasty falls within the Medicaid Provider Manual policy governing cosmetic procedures, set forth below:

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.

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The DCH-MHP contract provisions allow prior approval procedures for UM purposes. The MHP representative explained that for breast-reduction surgery, the MHP requires prior approval. In order to achieve prior approval, all of the following criteria[1] must be met:

A. The medical record must show documentation of at least 2 of the following criteria, present for at least 6 months and which have not responded adequately to appropriate, conservative, non-surgical interventions (including but not limited to):

   i. Back, neck or shoulder pain of long standing duration (6 months) that has been evaluated and determined not to be related to other diagnosis such as scoliosis, arthritis or of a mechanical nature, and that has not responded to at least three consecutive months of conservative measures including, but not limited to, all of the following:

      a) -Appropriate support bra (e.g. sports type with wide straps)

      b) -Exercises

      c) -Heat/cold treatments

      d) -Non-steroidal anti-inflammatory agents (NSAID's) and/or

1 Additional prior-authorization criteria has been omitted because it is not at issue in this case.

e) muscle relaxants.

ii. Ulnar paresthesia in which all other causes have been eliminated.

iii. Ulceration of the skin of the shoulder or significant and longstanding shoulder grooving not responding to conservative treatment over a 12-month period.

iv. Chronic interigo, eczema, dermatitis, and/or ulceration in the infra-mammary fold between the pendulous breasts and the chest wall. Not responsive to at least six months of dermatological treatment treatments [sic] (e.g. antibiotics and/or antifungal therapy) and conservative measures (e.g. good skin hygiene). By themselves, these dermatologic problems are not considered medically necessary indications for reduction mammoplasty.

(Exhibit 1, pages 17-18)

The MHP's Medical Director testified that the Appellant's request for prior approval of breast-reduction surgery was denied because the MHP had received no documentation to support that the Appellant meets the criteria for prior approval. Specifically, he testified that there was no documentation to support that the Appellant has undergone at least three consecutive months of conservative treatment for her back/neck pain, that she suffers from shoulder grooving, or that she suffers from significant skin breakdown because of the size of her breasts. (Testimony of [redacted]) The MHP's Manager of Patient Services further testified that efforts were made to obtain additional documentation from the Appellant's physicians. However, no additional documentation was received. (Testimony of [redacted])

The Appellant testified that she is five feet tall, and she wears an H cup bra. She explained that the size of her breasts prevents her from living a normal life. She cannot run, and climbing stairs takes her breathe away. She further testified that she has attempted some conservative treatment for back/neck pain: she attempted physical therapy for one month and she has used hot/cold treatments, NSAID pain relievers, and muscle relaxants for over a year. However, she did admit that she has not attempted to wear support bras because they are very expensive and the MHP does not cover them. She also testified that she has suffered from both shoulder grooving and on-going skin breakdown for quite some time. (Testimony of [redacted])

The Appellant provided this ALJ with the following medical documentation to support that she has satisfied the criteria for prior authorization: a cover sheet from the Appellant's treating physician, Dr. [redacted], confirming that he has treated her on several occasions for "recurrent cysts/back pain R/T breast size," along with a list of medications he has prescribed; a report from [redacted] Cancer Institute, confirming the Appellant's participation in the Genetics Registry; a physical therapy progress report from [redacted] Regional Medical Center, noting that the Appellant had been participating in

physical therapy since [redacted]; and several letters from various physicians regarding surgeries for hydradenitis in [redacted] and [redacted]. (Exhibit 2) Unfortunately, none of these documents link these treatments to the Appellant's breast size or need for reduction surgery. Indeed, it is not clear that the hydradenitis that the Appellant suffers is related to the Appellant's breast size, as it has also occurred in other unrelated areas, such as the Appellant's groin.

While this ALJ sympathizes with the Appellant's situation, the documentation provided does not support that she has met the criteria for prior approval of breast-reduction surgery. Accordingly, the MHP's denial was proper. However, the Appellant may re-apply for prior approval at any time should she obtain additional supporting documentation.

DECISION AND ORDER

The ALJ, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for breast-reduction surgery.

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 7/16/2010

***** 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.