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. 2010-43213 QHP

[redacted]

Appellant
_____/

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], Medicaid Director. [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/abdominoplasty surgery?

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 [redacted] Medicaid beneficiary who has been diagnosed with morbid obesity, localized adiposity/pannus, intertrigo, back and neck pain. (Exhibit 1, page 11)

2. On [redacted] the Department received a Prior Authorization request from the Appellant's physician for panniculectomy/abdominoplasty surgery. (Exhibit 1 pages 4 and 10-11)

3. On [redacted], the Department denied the Prior Authorization request because the coverage criteria were not met. (Exhibit 1, pages 8-9)

4. On [redacted], the Department received the Appellant's Request for a hearing. (Exhibit 1, page 1)

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.

As stated in the contract language above, MHP coverages and limitations must be consistent with Medicaid policy. On the Prior Authorization Form, the doctor indicated that the requested panniculectomy/abdominoplasty is considered plastic/reconstructive surgery. (Exhibit 1, page 11) The standards of coverage for cosmetic surgery can be found in the Practitioner section of the Medicaid Provider Manual:

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: July 1, 2010, Page 65
(Exhibit 1, page 6)

The submitted MHP policy also indicates that panniculectomy/abdominoplasty is most often a cosmetic procedure but may be covered in certain criteria are met, specifically:

a. Documentation by a dermatologist or an infections disease specialist that the panniculus causes recurrent episodes of infection that do not respond to treatment or recurrent non-healing ulcerations over 6 months despite appropriate medical therapy ***or***

b. Documentation by the treating physician that the panniculus directly causes, due to its size and weight, significant clinical functional impairment which is directly attributable to the size and weight of the panniculus. "Clinical functional impairment" exists when the pannus causes significant cardiopulmonary or musculoskeletal dysfunction, or major psychological trauma, that interferes with activities of daily living, and there is reasonable evidence to support that this intervention will correct the condition to which it is being attributed to.

Priority Health Medical Policy No. 91444-R4
Effective Date March 20, 2009, Pages 1-2.
(Exhibit 1, pages 2-3)

These criteria are consistent with the with the Medicaid cosmetic surgery standards of coverage for cosmetic surgery. The MHP documentation requirements also include frontal and lateral photographs of the pannus to document that it hangs below the level of the pubis, and documentation from the treating physician that has determined conservative management has failed and that a panniculectomy would resolve the symptoms. [redacted] *Medical Policy No. 91444-R4, Effective Date March 20, 2009, Page 2.* (Exhibit 1, page 3)

In the Appellant's case, the submitted clinical documentation did not include any documentation from a dermatologist or infectious disease specialist to meet criteria (a). Regarding criteria (b), the treating physician's [redacted] report notes back pain and a hard time moving. (Exhibit 1, page 7) Problems with balance, posture, fitting into clothing, running and exercise were noted in a [redacted] letter. (Exhibit 1, page 13) However, additional information regarding the extent to which these symptoms interfere with activities of daily living would have been helpful. For instance the Appellant described how the pannus effects her when going to the bathroom, and interference with everyday movements. (Appellant Testimony) Further, the MHP explained that the documentation requirements were not met and testified that they had not received the required photographs prior to the hearing.

Based on the information the MHP received with the prior authorization request, the denial of the panniculectomy/abdominoplasty surgery is upheld. The submitted information did not meet the MHP's criteria or documentation requirements. However, the MHP indicated they would accept additional documentation and reconsider the Appellant's request. While not admitted as exhibits at this hearing, the photographs and doctor's letter the Appellant sent to this ALJ prior to the hearing have been forwarded to the MHP.

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/abdominoplasty surgery based upon the information submitted with the prior authorization request.

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: 10/6/2010

***** 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.