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. 2010-52498 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. [redacted], represented the [redacted], the Medicaid Health Plan (MHP). [redacted], appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for a bilateral 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] female Medicaid beneficiary who is currently enrolled in the Respondent MHP, [redacted].

2. On [redacted], the MHP received a request for bilateral breast-reduction surgery from the Appellant's physician. The Appellant's physician noted that the Appellant has had increasing symptoms for several years, including back pain, shoulder pain, neck pain and intertriginous rashes. The pain is unrelieved by non-narcotic analgesics, and that the Appellant has had a problem with exercise and normal activity due to the weight and size of the breasts. The Appellant's physician noted that 1,000-1,500 grams or more 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 5-7)

3. On [redacted], and [redacted], the MHP sent letters to the Appellant's surgeon requesting additional information. (Exhibit 1, pages 8-9)

4. The MHP did not receive any additional information from the Appellant's surgeon's office. (Grievance Supervisor Testimony)

5. On [redacted], the MHP sent the Appellant a denial notice, stating that the request for bilateral breast-reduction surgery was not authorized because the requested additional information needed to review the prior authorization request was not received. Specifically, documentation of conservative treatment that was tried and failed and if there is a family or personal history of breast cancer. (Exhibit 1, pages 10-12)

6. The Appellant requested a formal, administrative hearing contesting the denial on [redacted]. (Exhibit 1, page 14)

7. The MHP subsequently requested and obtained additional records from the Appellant's primary care physician and the [redacted] [redacted]. (Exhibit 1, pages 16-23)

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. Breast-reduction surgery 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. The MHP utilizes the Milliman Care Guidelines for reduction mammaplasty in reviewing breast-reduction prior authorization requests. (Exhibit 1, pages 27-29) The MHP determined that the Milliman Care Guidelines criteria were not met with the documentation submitted with the prior authorization request, nor with documentation requested and received from the primary care physician subsequent to the Appellant filing the hearing request. Specifically, there has been no documentation provided regarding whether or not there is a family history of breast cancer, any treatments the Appellant has tried for her discomfort, or of any other co-morbidities. The RN explained that less invasive treatment must be tried first and other issues must have been ruled out as the cause of the Appellant’s pain. (RN Grievance and Quality Review Specialist Testimony)

The Appellant testified that she has tried lotions from the store for the rashes and that her primary care doctor is trying to get her started with physical therapy. She furhter testified

that her grandmother died from breast cancer.

While this ALJ sympathizes with the Appellant's situation, the MHP made reasonable attempts to obtain the documentation needed to support her prior authorization request. The Appellant's surgeon's office did not submit additional information despite two written requests. The documentation provided with the prior authorization request and by her other treatment providers does not support that she has met the criteria for prior approval of breast-reduction surgery. Accordingly, the MHP's denial was proper. 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.

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

cc:

Date Mailed: 11/24/2010

***** 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.