STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-5923 QHP
Case No. [redacted]

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 [redacted]. [redacted], represented [redacted], (hereinafter Medicaid Health Plan or MHP). [redacted], appeared on behalf of the Medicaid Health Plan.

[redacted] represented herself at hearing.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for 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 Medicaid beneficiary who is currently enrolled in [redacted], a Medicaid Health Plan (MHP).

2. The Appellant is an [redacted] female. She is [redacted] tall and her weight fluctuates between [redacted]. She attends [redacted] as a sophomore.

3. The Appellant has large breasts and is requesting prior authorization for breast reduction surgery.

4. The Appellant's medical conditions include back, neck and shoulder pain caused by breast size, shoulder grooves, increased thickness and hyperpigmentation of skin on her shoulders and underneath her breasts from her bras. She wears custom made bras as she is unable to purchase a ready to wear bra in her size at the store.

5. The Appellant's breasts are still growing. (uncontested evidence from the Appellant's correspondence dated [redacted], Department Exhibit A, page 17)

6. Medical documentation submitted with the request for prior authorization for the surgery indicates at least 700 grams of tissue could easily be removed from each of the Appellant's breasts if the surgery were to be performed. (Department Exhibit A)

7. The MHP's guidelines for prior approval of the surgery require, among other things, at least 1000 grams of tissue be removed from each of the Appellant's breasts, based upon her body surface area, before the surgery can be approved.

8. The Appellant requested prior authorization for breast reduction surgery [redacted].

9. [redacted] denied the request for prior authorization [redacted].

10. The Appellant filed an internal appeal with [redacted] on [redacted].

11. On [redacted], the Appellant's doctor sent a request, along with supporting medical documentation to [redacted], for use in the Appellant's internal appeal of the denial.

12. On [redacted], the internal appeal was denied. [redacted], the MHP denied the request after consulting their own internal criteria for breast reduction.

13. On [redacted], the Appellant submitted her Request for Hearing to the State Office of Administrative Hearings and Rules for the Department of Community Health.

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.

[redacted] 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 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.

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 and/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 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.
>
> *Michigan Department of Community Health*

The MHP denied the requested surgery for more than one reason. It cited the lack of medical documentation that sufficient breast tissue would be removed from each breast to fall within accepted guidelines evidencing the medical necessity of the surgery. The guidelines are in evidence as Department Exhibit A, pages 6-10. Additionally, [redacted] Medical Director cited the Appellant's own statement that her breasts had grown within a few months of the request for prior authorization and the denial. Her appeal request contained the admission that her breast size had increased. The Medical Director stated [redacted] own guidelines preclude prior authorization for the surgery unless the requestor's breasts had stopped growing. The Appellant asserted her breasts had stopped growing and further asserted there was medical documentation of this, however, could not cite any of it when asked by this ALJ to be directed to it.

As for the requirements set forth in the Medicaid Provider Manual, the Appellant did not provide sufficient evidence she met any of them. She is progressing in her studies at [redacted], apparently, not restricted in her pursuits as a result of her medical condition. She cited no evidence of inability to work. She had no evidence her breast size contributed to a major health problem, or that she is suffering a major health problem of any kind. There is no psychiatric evaluation in evidence, nor is the request part of a reconstructive process to correct a trauma or congenital deformity.

There is insufficient evidence of record the Appellant satisfies the criteria set forth in the Medicaid Provider Manual or [redacted] own criteria. There is no evidentiary basis that could allow for the denial to be overturned. While this ALJ does sympathize with her plight, the guidelines establish what criteria must be satisfied to establish the procedure is medically necessary and she has not supplied adequate evidence to refute the Health Plan's denial.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the MHP properly denied the Appellant's prior authorization request for Reduction Mammoplasty.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/20/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health 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 for the Department of Community Health 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.