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

IN THE MATTER OF:

Docket No. 2011-14736 QHP
Case No. [redacted]

[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.,* following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant, [redacted], was present. The Appellant's physician, [redacted], represented her. [redacted], represented [redacted], the Medicaid Health Plan (MHP). [redacted] and [redacted], 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 on the competent, material, and substantial evidence presented, the Administrative Law Judge finds, as material fact:

1. The Appellant is a [redacted] female Medicaid beneficiary who is currently enrolled in the Respondent MHP, [redacted]. She is 5 feet 2 ½ inches tall and weighs 217 pounds. Her body mass index (BMI) is 39.1, and her bra size is 46 DDD. (Exhibit 1, page 2)

2. On [redacted], the MHP received a request for breast-reduction surgery from the Appellant's physician. The Appellant's physician noted that more than 1000 grams of tissue would be removed from the Appellant's breasts and that the Appellant had complained of the following symptoms: heaviness of the breasts, neck and shoulder tenderness, sweating and maceration of the inframammary line, and shoulder grooving. (Exhibit 1, pages 7-10; Exhibit 2, page 3)

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 preoperative waist-to-shoulder, lateral photograph submitted with the request; the information submitted did not indicate the duration of the Appellant's symptoms or any documented failure of conservative treatment, such as analgesics, support bras, exercises, heat/cold therapy, or non-steroidal medications; the Appellant has not maintained a BMI of less than 25 for 12 consecutive months; and a psychological assessment has not been conducted on the Appellant. (Exhibit 1, pages 11-15)

4. On [redacted], the Appellant's physician responded to the MHP's denial. He provided some responses to the requested information, but he did not provide any clinical documentation to support those responses. In addition, he challenged some of the requests for information as being unnecessary in his opinion, and he referred the MHP to the clinical practice guidelines. (Exhibit 1, pages 20-21)

5. In response to the letter from the Appellant's physician, the MHP had another physician review the Appellant's request for breast reduction, and that physician agreed with the denial because of the lack of documentation to support the request. (Exhibit 1, pages 37-42)

6. The Michigan Administrative Hearing System received a signed Request for Hearing on [redacted]. (Exhibit 2)

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.
>
> *Michigan Department of Community Health*
> *Medicaid Provider Manual; Practitioner*
> *Version Date: October 1, 2010*
> *Page 65*

The DCH-MHP contract provisions allow prior approval procedures for UM purposes. The MHP witnesses explained that for breast-reduction surgery, the MHP requires that all of the following criteria be met:

> Policy/Criteria
>
> Reduction Mammoplasty may be considered for adult female members only if all of the following conditions are met:

- The member has debilitating symptoms solely due to macromastia, and
- Condition interferes with employment or ADL's **or**
- Causes significant disability or psychological trauma as documented by psychiatric evaluation **or**
- It is a component of reconstructive surgery following mastectomy or trauma **or**
- It contributes to a major health problem including but not limited to;
    - Chronic intertrigo, dermatitis or ulceration caused by breast folds
    - Confirm diagnosis of acquired kyphosis, compensatory lordosis or scoliosis
    - Shoulder grooving from bra straps
    - Neck, shoulder or chest pain
- Psychological assessment (required)
- Behavioral health consultation and interventions have been performed as appropriate
    - Stress Management
    - Stimulus Control

2. The member must be;
    - 18 years of age or older **and**
    - Not pregnant **and**
    - Not delivered a child within the past year
3. Morbid Obesity (BMI>35) is present and member is unresponsive to medically supervised weight loss management.

* * *

4. Medical record must document response to previously prescribed interventions and substantiate the condition being refractory and non-

invasive therapies.

* * *

Documentation Requirements

The treating physician must provide documentation to establish diagnosis of macromastia, the intractability to medical treatment, and all other conditions outlined in the Policy/Criteria and Contraindications section of this policy. Clinical documentation must be submitted with the request for prior authorization and also includes the following:

- Medical necessity
- Complete history and physical assessment
- Pre-operative mammography to rule out paranchymal breast disease

(Exhibit 1, pages 44-45)

The MHP's Medical Director testified that the Appellant's request for prior approval of breast-reduction surgery was denied because the MHP had not received the documentation required 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 participated in a weight management program, an exercise program, or a nutritional program. In addition, the Appellant's physician failed to provide any documentation to support that the Appellant had undergone a psychological assessment. He explained that the MHP is concerned about surgical correction of obesity and wants to ensure that the underlying issue of obesity is addressed before authorizing any corrective surgery. The MHP attempted to obtain additional documentation from the Appellant's physician. However, no additional documentation was received.

The Appellant is 5 feet 2 ½ inches tall, and she wears a DDD cup bra. Her physician testified that he does not believe that the information requested by the MHP in order to authorize the surgery is relevant. He acknowledged that, for this reason, he did not submit all of the requested information to the MHP. The Appellant confirmed that she has not undergone a psychological evaluation. She stated that she did attend a health fitness class in [redacted] and [redacted]. However, she gained all of that weight back.

While this Administrative Law Judge sympathizes with the Appellant's situation, she bears the burden of proving, by a preponderance of the evidence that she met all of the criteria for coverage of breast-reduction surgery. She did not meet her burden here. Accordingly, the MHP's denial was proper. However, the Appellant may re-apply for prior approval at any time.

DECISION AND ORDER

The Administrative Judge Law, 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 Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5/17/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.