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:

[redacted],

Docket No. 2011-52190 QHP
Case No. [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] appeared on behalf of the Appellant. At hearing he declined to represent. The Appellant proceeded without representation. Her witness was her father, [redacted]. [redacted], Director, Member Services represented the Medicaid Health Plan (MHP). Her witness was [redacted]

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for breast reduction 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. At the time of hearing the Appellant is a [redacted] Medicaid beneficiary.

2. The Appellant is enrolled in the [redacted]. She has been a member since [redacted].

3. On [redacted], the MHP received a request for bilateral breast reduction.

4. On [redacted], that request was denied because the Appellant failed to meet criteria for coverage – medical conditions extant for a 6-month period which have not responded to conservative treatment. Respondent's Exhibit A, pp. 46-50.

5. Following the Appellant's requested internal appeal the Appellant's record was sent out for independent review by a board certified plastic surgeon from the [redacted]. That physician reviewer upheld the original denial decision. Respondent's Exhibit A, pp. 52-57.

6. At hearing the Appellant alleged Migraine headaches since age [redacted], random numbness across her arms and back with neck pain from grooving in her arms. She said her neck gets stiff with low back pain, anxiety and shoulder numbness. See Testimony.

7. The Appellant alleges bi-polar disorder. Appellant's Exhibit #1, pp. 2, 5, 6.

8. On [redacted], the MHP advised the Appellant that the denial was confirmed on independent review for lack of documentation to demonstrate [2 for at least six months] no response to conservative treatment: ulnar paresthesia, ulceration, ongoing skin problems. Respondent's Exhibit A, pp. 56-57 and see testimony of [redacted].

9. The Appellant has macromastia (very large breasts). Respondent's Exhibit A, p. 2.

10. The instant appeal was received by the Michigan Administrative Hearing System for the Department of Community Health on September 1, 2011. Appellant's Exhibit #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. 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.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor

- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21

Contract §1.020 Scope of [Services],
at §1.022 E (1) 2010, p. 22 *et seq*

Additionally, the MHPs are restricted by contract and the MPM from providing the service of elective cosmetic surgery.[1] The criteria for approval of cosmetic procedures under the MPM are exacting:

> 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. Physicians should refer to the General Information for Providers Chapter for

[1] See MPM, Medicaid Health Plans, §1.3, *Supra*

> specific information for obtaining authorization. (Emphasis supplied)
>
> MPM, Practitioner, §13.2, October 1, 2011, pages 62, 63.

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At hearing the MHP witnesses testified that there was no evidence the requested surgery was medically necessary to alleviate the afflictions of ulnar paresthesia, shoulder ulcerations or skin breakdown [chronic intertrigo] which was unresponsive to treatment.

The MHP physican testified that the photographs sent in did not demonstrate shoulder grooving or skin changes – which hadn't responded to conservative treatment. The MHP witness also stated that the documentation submitted did not establish whether or not the Appellant was afflicted with any endocrine or metabolic condition which might have contributed to the Appellant's macromastia. [redacted] opined that a serious nerve condition might be resolved with surgery – but the information submitted did not support either that problem or mammaplasty as a solution.

The Appellant testified that her breasts interfere with her employment causing her to "lag behind" her co-workers and by the production of a "stiff neck" requiring "frequent breaks." She said she has tried physical therapy and the maintenance of good posture with out satisfactory results.

The Appellant's father verified factual details of her testimony and pursuit of treatment.

On review – the Appellant's problem is that she is an otherwise healthy young woman. Cosmetically, this reviewer is certain that she qualifies for mammaplasty – but the Medicaid program requires proof of medical necessity which was absent here.

Owing to her youth and relative good health she did not present with evidence of the type of shoulder grooving and skin wounds or condition that would cause a medical evaluator [subject to Medicaid restrictions] to investigate further for proof of medical necessity. Under Medicaid policy cosmetic surgery is permitted in only a few narrow circumstances – as referenced above.

The Appellant only touched briefly upon two areas beyond the cosmetic quality that could militate towards approval – that of interference with employment or a resulting psychological trauma. There was no documentation to preponderate on either of these conditions in her testimony or exhibit.

While the logic of mammaplasty as a "pain reliever" seems obvious - the risk of surgery when conservative treatment is shown to be effective militates against proof of medical necessity or satisfaction of MHP policy. *See* Respondent's Exhibit A, at pages 58 – 61.

The Appellant has not preponderated her burden of proof.

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 breast reduction surgery.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/29/2011

***** 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.