

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

██████████,

Appellant

Docket No. 2011-52485 QHP
Case ██████████

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 ██████████, the Appellant, appeared and testified.

██████████, Director of Member Services, represented ██████████, the Medicaid Health Plan (hereinafter MHP). ██████████, Associate Medical Director, appeared as a witness for the MHP.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for panniculectomy, abdominoplasty, brachioplasty, and thighplasty 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 ██████ year-old Medicaid beneficiary.
2. On ██████████, the MHP received a Prior Authorization request from the Appellant's plastic surgeon for panniculectomy, abdominoplasty, bilateral thighplasty, and bilateral brachioplasty surgery. Additional medical documentation was attached indicating the Appellant has rheumatoid arthritis and underwent bariatric surgery in ██████. The plastic surgeon's office notes indicate his examination showed heavy arms, and excessive tissues of the thigh. Abdominal examination did not show any hernia but it looked like pus coming from the umbilical area. Photographs

were also included. (Exhibit 1, pages 17-26)

3. On ██████████, the MHP issued denial letters to the Appellant and the plastic surgeon stating that the requested procedures were not authorized because the clinical information submitted did not support the MHP's medical policies for panniculectomy & abdominoplasty, and cosmetic surgery. (Exhibit 1, pages 28-31)
4. Between ██████████, and ██████████, documents for the Appellant's appeal were received by the Michigan Administrative Hearing System. (Exhibit 1, pages 2-10)
5. On ██████████, the MHP issued a letter to the Appellant indicating that a physician reviewer determined that the criteria for coverage were not met. Regarding the panniculectomy and abdominoplasty, the submitted pictures showed the panniculus hangs below the pubis, but the notes did not show that it causes chronic infections that consistently recur over three months while receiving medical therapy, and remains resistant to medical therapy over a three month period. The thigh lift and arm lift are considered cosmetic surgery and there were no notes showing the condition interferes with employment, causes a significant disability or psychological trauma, the surgery is being done as a component of reconstructive surgery for a congenital deformity or trauma, or that it contributes to a major health problem. The MHP only covers medically indicated cosmetic removal of extra skin and subcutaneous tissue when these procedures are performed due to another surgery being done at the same time and would affect the healing of the surgical incision. (Exhibit 1, pages 15-16)

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 Department-MHP contract language above, a MHP, “must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations.” The pertinent section of the Michigan Medicaid Provider Manual (MPM) states:

:

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, 2011, Page 64*

Under the DCH-MHP contract provisions, an MHP may devise their own criteria for coverage of medically necessary services, as long as those criteria do not effectively avoid providing medically necessary services.

The MHP’s Medical Policy for Abdominoplasty, Panniculectomy, Suction Lipectomy, Lipoabdominoplasty, and Ventral Hernia Requests states:

III. Criteria

A. Panniculectomy/Abdominoplasty

1. The procedure must be prior-authorized by Health Plan of Michigan (HPM).
2. HPM considers panniculectomy medically necessary according to the following criteria:
 - a. Panniculus hangs below the level of the pubis; *and*

- b. The medical records document that the panniculus causes chronic intertrigo (dermatitis occurring on opposed surfaces of the skin, skin irritation, infection or chafing) that consistently recurs over 3 months while receiving appropriate medical therapy, or remains refractory to appropriate medical therapy over a period of 3 months.
3. HPM considers panniculectomy cosmetic when these criteria are not met.
4. If the procedure is being performed following significant weight loss, in addition to meeting the criteria noted above, there should be evidence that the individual has maintained a stable weight for at least six months. If the weight loss is the result of bariatric surgery, abdominoplasty/panniculectomy should not be performed until at least 18 months after bariatric surgery and only when weight has been stable for at least the most recent six months.
5. Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty) (15830) will only be considered reasonable and medically necessary when these procedures are performed due to another surgery being done at the same time and would effect the healing of the surgical incision.
6. This procedure may also be considered to be medically necessary for the patient that has had a significant weight-loss following the treatment of morbid obesity and there are medical complications such as candidiasis, intertrigo or tissue necrosis that is unresponsive to oral or topical medication.
7. Pictures of documentation prior to authorization.

B. Ventral Hernias/Diastasis recti

1. HPM considers repair of a true incisional or ventral hernia medically necessary. In order to distinguish a ventral hernia repair from a purely cosmetic abdominoplasty, HPM requires documentation of the size of the hernia, whether the ventral hernia is reducible, whether the hernia is accompanied by

pain or other symptoms, the extent of diastasis of the rectus abdominus muscles, whether there is a true defect (vs. thinning) of the abdominal fascia, and clinical notes indicating the presence and size of the fascial defect.

2. HPM considers repair of a diastasis recti, defined as a thinning out of the anterior abdominal wall fascia, not medically necessary because, according to the clinical literature, it does not represent a “true” hernia and is of no clinical significance.

C. Suction Lipectomy/Lipoabdominoplasty

HPM considers suction lipectomy or lipoabdominoplasty to be cosmetic because they are not associated with functional improvements.

(Exhibit 1, pages 41-43)

The MHP Medical Policy for Cosmetic Surgery states:

III. Criteria

A. Cosmetic Surgery

HPM only covers medically indicated cosmetic surgery if PA has been obtained. The physician may request PA if any of the following exist (requesting a PA does not mean the procedure has been approved; it needs to be reviewed for meeting criteria and medical necessity):

1. The condition interferes with employment.
2. It causes significant disability or psychological trauma (as documented by psychiatric evaluation).
3. It is a component of a program of reconstructive surgery for congenital deformity or trauma.
4. 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, as well as photographs to support the medical documentation.

B. Scar Revision

The following procedures will be considered on an individual basis:

1. The scar causes chronic symptoms
 - a. Documentation of chronic pain requiring medication or limiting activities of daily living,
 - b. Documentation of ulcerated or inflamed scar despite medical management
 - c. Photograph of scar

- C. Excision of excessive skin and subcutaneous tissue
 1. Must be considered reasonable and medically necessary when these procedures are performed due to another surgery being done at the same time and would affect the healing of the surgical incision.
 2. Photograph must be provided as well as description of planned surgical incision that would heal improperly unless excision or excessive skin and subcutaneous tissue is performed.

(Exhibit 1, pages 45-46)

These criteria are consistent with the Medicaid standards of coverage for cosmetic surgery, do not effectively avoid providing medically necessary services and are allowable under the DCH-MHP contract provisions.

In this case, the Appellant did not meet the MHP criteria based on the information available at the time the ██████████, prior authorization request was reviewed. The submitted documentation did not document chronic skin problems that consistently recurred while receiving appropriate medical therapy, or remained refractory to appropriate medical therapy. The ██████████, letter from ██████████ notes yeast infections due to the excess skin, but does not document the area of the body where the yeast infections occur, what treatments have been tried, how long any treatments were tried, the results of any treatment, or the frequency of recurrence. (Exhibit 1, page 4) A ██████████, office visit note, which does not appear to be completed, was also submitted. This office visit note also fails to document any treatment attempts for skin problems. The doctor document's the Appellant's multiple complaints regarding her excess skin and tissues on her arms, thighs and abdomen. However, the only documented physical exam findings were heavy arms and excessive tissues of the thigh. The abdomen examination did not show any hernia, but it looked like pus coming from the umbilical area. (Exhibit 1, pages 8 and 21) Accordingly, the submitted documentation does not establish that the Appellant met either criteria 2(b) or 6 of the MHP's Panniculectomy/Abdominoplasty medical policy. For criteria 5 to be met, the

documentation would have to have established that the excision of excessive skin and subcutaneous tissue was being performed due to another surgery being performed at the same time and would affect the healing of the surgical incision.

The requested procedures were also considered under the MHP's cosmetic surgery criteria. The submitted documentation did not show a condition that interferes with employment, causes significant disability or psychological trauma (as documented by psychiatric evaluation), is a component of a program of reconstructive surgery for congenital deformity or trauma, or contributes to a major health problem. In addition to the medical documentation discussed above, a ██████████, letter from ██████████ and ██████████ was submitted. This letter states that the Appellant's excess skin may be causing increased stress on her joints. However, this letter also indicates the doctors concern that the Appellant's rheumatoid arthritis is not adequately controlled on the current medications, and new medications were added. This letter also notes additional diagnoses of fibromyalgia and bipolar disorder, which make an accurate assessment of the Appellant's arthritis activity challenging. (Exhibit 1, pages 6-7 and 18-20) Accordingly, the submitted documentation does not establish that the Appellant met criteria A of the MHP's medical policy for Cosmetic Surgery. Criteria B can not apply as the requested procedures were not scar revision. For criteria C to apply the documentation would have to have established that the excision of excessive skin and subcutaneous tissue was being performed due to another surgery being performed at the same time and would affect the healing of the surgical incision, including a description of the planned surgical incision that would heal improperly unless the excision is performed.

Additional documentation would be needed to establish that the Appellant met the criteria for Panniculectomy/Abdominoplasty and/or Cosmetic Surgery. The MHP's denial of the requested panniculectomy, abdominoplasty, brachioplasty, and thighplasty surgery is upheld based on the submitted documentation.

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, brachioplasty, and thighplasty surgery based upon the documentation submitted.


Docket No. 2011-52485 QHP
Decision and Order

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: 

Date Mailed: 2011-52485 QHP

***** NOTICE *****

The Michigan Administrative Hearing System 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.