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. 2012-16397 QHP
Case [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]. [redacted], the Appellant, appeared and testified.

[redacted], Director of Member Services, represented [redacted] (formerly [redacted]), the Medicaid Health Plan (hereinafter MHP). [redacted], Medical Director of Quality, appeared as a witness for the MHP.

ISSUE

Did the Medicaid Health Plan properly deny the Appellant's request for panniculectomy, abdominoplasty, and lipectomy 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 [redacted] year-old Medicaid beneficiary.

2. On [redacted], the MHP received a Prior Authorization request from the Appellant's plastic surgeon for panniculectomy, abdominoplasty, and lipectomy surgery. Additional medical documentation was attached. (Exhibit 1, pages 7-10)

3. On [redacted], the MHP issued a denial letter 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 abdominoplasty, panniculectomy, suction lipectomy, lipoabdominoplasty, and ventral hernia surgery. The denial notice indicates no notes or pictures were sent to show the panniculus hangs below the pubis, or that is causes chronic intertrigo that consistently recurs over three months while receiving medical therapy and remains refractory to medical therapy over a period of three months. (Exhibit 1, pages 11-15)

4. On [redacted], the Appellant submitted an Internal Grievance/Appeal form to the MHP with additional documentation. (Exhibit 1, pages 16-25)

5. On [redacted], the MHP received additional documentation regarding the Appellant. (Exhibit 1, pages 26-28)

6. On [redacted], an external review of the Appellant's prior authorization request with the additional documentation was completed. (Exhibit 1, pages 29-32)

7. On [redacted], the MHP issued a Notification of Appeal Decision to the Appellant and the plastic surgeon upholding the original denial decision. (Exhibit 1, pages 34-35)

8. On [redacted], the Appellant's request for Hearing was faxed to the Michigan Administrative Hearing System. (Exhibit 1, page 3)

9. On [redacted] the MHP received additional pictures for the Appellant's appeal. (Exhibit 1, page 36)

10. On [redacted] the MHP issued a letter to the Appellant regarding a Level 2 grievance/appeal of the denied service indicating the prior authorization request remains denied. (Exhibit 1, pages 37-38)

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: October 1, 2011, Page 62*

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 lest 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 (abdomenoplasty) (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 39-41)

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 is 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 43-44)

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 times the [redacted], prior authorization request was reviewed. The submitted documentation does not contain a good photograph to show that the panniculus hangs below the level of the pubis nor did it document chronic skin problems that consistently recurred while receiving appropriate medical therapy, or remained refractory to appropriate medical therapy for over three months. (Exhibit 1, pages 7-8, 10, 17-28, and 36)

Only four photographs were submitted, but the picture quality is poor and does not establish a panniculus that hangs below the level of the pubis. (Exhibit 1, pages 27-28 and 36) The Appellant asserted that pictures in the MHP's hearing exhibit are not pictures of her body. This ALJ notes that some of the documentation in the MHPs exhibit, including two pages containing photographs, show a different last name for the

Appellant. (Exhibit 1, pages 27-28) However, the Neurologist report lists the Appellant with both of the last names. (Exhibit 1, page 19) The Appellant also listed both names on authorizations to release medical information. (Exhibit 2, pages 12 and 17) If the pictures submitted to the MHP are of a different patient, the Appellant can always have her doctors re-submit pictures of the Appellant's body to support a new prior authorization request for the procedure.

Regarding documentation to establish chronic skin problems, the [redacted], letter from the dermatologist documents a rash had been present for two weeks and prescriptions were given. (Exhibit 1, page 17) There is no follow up documentation from this dermatologist. In her testimony, the Appellant indicated that she saw a second dermatologist the week prior to the [redacted], hearing proceedings. No documentation from this dermatologist was submitted. This ALJ has also reviewed the additional 20 pages of documentation the Appellant submitted for the [redacted], hearing proceedings. It did not contain documentation of three consecutive months of medical therapy for skin problems to establish recurrence or skin problems refractory to treatment. (Exhibit 2) The documentation of the dermatologist visit for a rash of two weeks duration with no follow up notes and of two rejected pharmacy claims in [redacted] and [redacted] is not sufficient. (Exhibit 1, page 17 and Exhibit 2, pages 5 and 15-16) Clinical documentation is needed to show the duration of treatment attempts and Appellant's responses to the treatment attempts.

The Appellant also asserted that the MHP could have done more to obtain the needed documentation, including getting records from a different surgeon who had everything in order to perform the requested procedure if the Appellant had been able to afford the cost. However, the MHP can only base their determination on the documentation the Appellant's doctors have provided. While another surgeon may have decided that the Appellant was a good candidate for this procedure, he likely would have used different criteria. Medical necessity must be established for Medicaid covered services. The denials issued by the MHP explained what documentation was lacking. (Exhibit 1, pages 12-15, 34-35, and 37-38) At any time, the Appellant's doctor(s) can submit a new prior authorization request with the needed documentation to establish the medical necessity of the requested procedures. The MHP's denial of the requested panniculectomy, abdominoplasty, and lipectomy 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, and lipectomy surgery based upon the documentation submitted.

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: [redacted]

Date Mailed: 3/1/2012

***** 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.