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. 2012-47419 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]. The Appellant appeared without representation. She had no witnesses. [redacted] Appeals Coordinator, represented [redacted], the Medicaid Health Plan (MHP). She had no witnesses.

Also in attendance was [redacted] employee-in-training, [redacted]

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for Rhinoplasty?

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]

2. The Appellant is afflicted with sinusitis and nasal deformity. [redacted]

3. Her physician sought prior approval PA for Rhinoplasty. [redacted]

4. On [redacted] the MHP advised the prior authorization (PA) requestor that the MHP denied the request for lack of adequate medical documentation. [redacted]

5. The Respondent testified that the MHP received 2 pages of material – a

written summary and a consultation letter. [redacted]

6. The Appellant testified that she had all of the testing, CAT scans and related photography – she was unclear why the physican did not send the material to the MHP. [redacted]

7. The Respondent advised the Appellant to take her denial letter to her physician to show the listing of required information. She agreed to do so. [redacted]

8. The Appellant did not withdraw her petition.

9. The requesting healthcare provider and the Appellant were advised of the denial on [redacted] Her further appeal rights were contained therein. [redacted]

10. The instant request for hearing was received by the Michigan Administrative Hearing System on [redacted]

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 Health Plan of Michigan 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

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2010, p. 22.

....

A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. In this instance the Appellant failed to preponderate that the requested Rhinoplasty was medically necessary - based on a lack of medical evidence.

The Department witness testified that there was insufficient medical documentation that proof of a need for Rhinoplasty was present or that alternative methods of treatment had been explored.

The Appellant said she had undergone all of the testing referenced by the Respondent and did not understand why the physican failed to send that material. She was advised to take her denial letter to her physican to show the necessary information that the MHP requires for evaluation and approval of Rhinoplasty surgery.

Under its contract with the Department, an MHP is permitted to establish medical necessity criteria. In this case the MHP simply failed to receive adequate information - in the face of a request for a serious surgical procedure.

Based on the evidence presented today I conclude that the MHP has properly denied the Appellant's request for Rhinoplasty.

DECISION AND ORDER

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

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 Signed: _____

Date Mailed: 7/12/2012

***** NOTICE *****

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.