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. 2012-50462 QHP

[redacted] 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 and testified on her own behalf. [redacted] represented the [redacted] and testified.

ISSUE

Did [redacted] properly deny the Appellant's prior authorization 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. The Appellant is a [redacted] Medicaid beneficiary, enrolled in [redacted] resides in her [redacted] home.

2. The Appellant's medical records indicate that the Appellant has been diagnosed with back, shoulder, and neck pain, and chronic skin rashes due to her large breasts.

3. The Appellant is currently receiving physical therapy for her neck, shoulder and back pain.

4. On [redacted] the Appellant's physician [redacted] certified plastic surgeon submitted a prior authorization request with [redacted] for bilateral breast reduction.

5. [redacted] received the Appellant's request for bilateral breast reduction and reviewed the request

6. On [redacted] that request was denied because [redacted] staff concluded that the medical documentation provided by Appellant showed that the Appellant failed to meet criteria for coverage.

7. Following [redacted] internal appeal process [redacted] sent the Appellant's record out for independent review by a board certified plastic surgeon from the [redacted] That physician reviewer concurred with [redacted] original denial decision.

8. On [redacted] [redacted] sent the Appellant written notice that it had reviewed the Appellant's level 2 grievance/ appeal and determined that the Appellant's request for bilateral breast reduction was denied. In the denial letter Meridian informed the Appellant that the documentation provided did not show that the Appellant had two conditions present for at least 6 months that have not responded to conservative (non- surgical) treatment.

9. On [redacted] the Appellant's appeal was received by the Michigan Administrative Hearing System.

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 overages

and limitations. If new servic es are added to the Michigan Medicaid Program, or if serv ices are expanded, eliminated, or otherwise changed, the Contra ctor must implement the changes c onsistent with State di rection in accordanc e with the provisions of Contract Section 2.024.

Although the Contractor must provide t he full range of covered services listed below they may choose to provide services over and above thos e specifie d. The c overed services pr ovided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testi ng in accordanc e 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 procedur es, lim ited 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 re habilitative 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 – maxi mum 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 developmental 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.

The MDCH-MHP contract language allows a health plan such as [redacted] to limit services to those that are medically necessary and consistent with Medicaid policy. [redacted] policy and Procedure Manual policy for Reduction Mammaplasty, Mastopexy, Gynecomastia surgery provided in pertinent part:

III. Criteria

1. The procedure must be prior authorized by Meridian Health Plan.
2. A reduction, Mammaplasty will be covered for Meridian Health Plan members meeting all the following criteria.
   A. The medical records must show documentation of a least 2 of the following criteria, present for at least 6 months and which have not responded adequately to appropriate conservative, non- surgical interventions(including but not limited to:
   i. Back, neck or shoulder pain of long standing duration(6months) that has been evaluated and determined not

to be related to other diagnosis such as scoliosis, arthritis or of a mechanical nature, and that has not responded to at least three consecutive months of conserva tive measure including, but not limited to all of the following:

a) Appropriate support bra (e.g. sports type with wide straps
b) Exercises
c) Heat/cold treatments
d) Non steroidal anti- inflammatory agents(NSAID's) and/ or
e) muscle relaxants

ii. Ulceration of the skin of the shoulder or signific ant and long s tanding s houlder grooving not responding to conservative treatment over a 12- month period.

iii. Chronic intertrigo, eczema, dermatitis, and/ or ulceration in the intra-ma mmary fold between the pendulous breasts and the ch est wall, not r esponsive to at least six months of dermatologic treatments (e.g. antibiotics and/ or antifungal therapy) and conservative measure (e.g. good skin hygiene). By themselves. These dermatol ogical problems are not considered medically necessary indic ations for mammoplasty.

Dept/ Meridian Ex. 1 pp. 73-74

The undisputed evidence shows that on [redacted] the Ap pellant's physic ian, [redacted]., a board c ertified plastic surgeon, submitted a prior authorization request with [redacted] for bilate ral breas t reduction. On [redacted], [redacted] denied the request. [redacted] staff concluded that the medical doc umentation provided f ailed to show that the Appellant met criteria fo r coverage. It is also not disputed that the Appellant has large breasts and chronic neck, shoulder and back pai n and chronic skin rashes. The Appellant is currently being treated with physic al therapy and the medications [redacted] and [redacted] for pain.

[redacted] [redacted] testified for [redacted] that the Appellant has large breasts which arguably are contributing to the App ellant's sy mptoms. [redacted] testified that the documentatio n provided by the Appella nt's medical provider indic ated that breast reduction surgery was not medically [redacted] testified that he reviewed the medical document ation submitted by the Appella nt's physician and health care providers and concluded t hat there was not sufficient documentation to show that the Appellant's pain and skin ra shes had been treated for six months or more through conservative treatments that had failed. [redacted] testified that the medica l documentation shows that the Appellant has neck, shoulder and back pain but there is not enough documentation to show that the Appellant's breas ts are the cause of the

pain. [redacted] testified that there is documentation which shows that the Appellant has shoulder grooving but sparse documentation that bra alternatives have failed. [redacted] testified that the documentation shows that the Appellant [redacted] receiving physical therapy and medication for her pain and that this conservative treatment must continue for six month or more or fail before breast surgery would be medically necessary.

[redacted] also testified that the documentation shows that the Appellant's skin rashes are being treated with topical medications and not antibiotics. [redacted] testified that there is no documentation that the Appellant's breasts are causing skin infections that can't be treated by antibiotics and other medications. [redacted] testified that if documentation was provided that the Appellant's skin rashes did not respond to six months ore more of conservative treatments then breast reduction surgery might be medically necessary.

[redacted] testified that the documentation provided does not show that the Appellant's medical condition meets a least 2 of the breast reduction surgery criteria because the documentation does not show that any condition has been present for at least 6 months and has not responded adequately to appropriate conservative, non-surgical interventions.

The Appellant testified that she has shoulder grooving and has tried multiple bra alternatives with no success. The Appellant testified that she has neck, back and shoulder pain and her pain is not relieved through physical therapy or medication. The Appellant testified that she has chronic skin rashes and has been prescribed medication. The Appellant testified that she feels that she and her medical providers have attempted to treat her pain, shoulder grooving and rashes but so far all treatments have failed. The Appellant believes that breast reduction surgery is the only means to treat her medical conditions.

There is medical documentation that the Appellant has shoulder grooving and has tried some bra alternatives. There is medical documentation which shows that the Appellant has chronic pain and chronic skin rashes. However, I agree with [redacted] that the documentation does not show that the Appellant's pain and skin rashes have been conservatively treated for 6 months or more and all conservative treatments have failed. I find based on the evidence submitted that [redacted] properly denied the Appellant's prior authorization request for breast reduction surgery because the medical documentation submitted does not show that the Appellant meets Medicaid coverage criteria.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Meridian Health Plan of Michigan properly denied the Appellant's prior authorization request.

IT IS THEREFORE ORDERED that:

The Meridian Health Plan of Michigan's decision is AFFIRMED.

Martin D. Snider
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: _____

***** 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.