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) 373-4147

IN THE MATTER OF:

Docket No. 2013-19899 QHP

[redacted]

Appellant

[redacted]/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted] the Appellant, appeared and testified. [redacted] husband, appeared as a witness for the Appellant. [redacted], Paralegal, represented [redacted] the Medicaid Health Plan (MHP). [redacted], RN Case Manager, and [redacted], Interim Plan Director, appeared as a witness for the MHP. [redacted], from the [redacted] of the MHP, provided translation. The record was left open for the MHP to submit additional documentation, which has been received.

ISSUE

Did the MHP properly deny the Appellant's request for endovenous laser ablation treatment?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is a Medicaid beneficiary who is currently enrolled in the Respondent MHP, [redacted]

2. On or about [redacted] the MHP received a request for endovenous laser ablation therapy for the Appellant. (Exhibit C)

3. On [redacted] the MHP sent the Appellant a denial notice, stating that the request for the procedure to get rid of veins was denied under the MHP's rules. The MHP reviewed the information from the doctor but some information was missing or did not meet the rules. It was noted that the MHP needs to see: the duplex report, the formal reading of the report, that the vein size meets the rules for veins to be done, what skin problems

[redacted]

the Appellant has because of the large veins, how those cause a functional problem, and what activities are limited because of the large veins. (Exhibit A)

4. On [redacted] the Appellant's Request for Hearing was received by the Michigan Administrative Hearing System.

5. After the request for hearing was filed, the MHP's Medical Director reviewed the Appellant's request and medical records. The MHP's Medical Director recommended the Appellant get a second opinion by an in network specialist, and if the second opinion concurs that surgery is necessary, the MHP would approve payment. (Hearing Summary and Interim Plan Director Testimony)

6. On [redacted], the Appellant saw an in network specialist for a second opinion. (Exhibit D)

7. On [redacted] a Bilateral Lower Extremity Venous Duplex Evaluation with Reflux Testing was completed. (Exhibit E)

8. On [redacted] and [redacted] the second opinion specialist evaluated the Appellant. (Exhibits F and G)

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 MHPs.

The Respondent is one of those MHPs.

> 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

[redacted]

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

[redacted]

- 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.

(1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:
(a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
(e) The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

[redacted]

(2) Prior Approval Policy and Procedure

> The Contractor must establish and use a written prior approval policy and procedure for UM 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.
>
> ....

Contract, *Supra,* p. 49

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 sections of the Michigan Medicaid Provider Manual (MPM) state:

> **SECTION 12 – SURGERY – GENERAL**
>
> Medicaid covers medically necessary surgical procedures.
>
> *Michigan Department of Community Health,*
> *Medicaid Provider Manual, Practitioner*
> *Version Date: October 1, 2012, Page 58*
>
> **13.3 COSMETIC SURGERY [RE-NUMBERED 4/1/12]**
>
> 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.

[redacted]

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 specific information for obtaining authorization.

Michigan Department of Community Health,
Medicaid Provider Manual, Practitioner
Version Date: October 1, 2012, Page 64.

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviewed this prior approval request under the UnitedHealthcare Coverage Determination Guideline for Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins. (Exhibit B) In part, the guidelines required documentation and criteria for a reconstructive coverage determination state:

I. Required Documentation:

The decision regarding whether the requested procedure will be covered as reconstructive or excluded from coverage as cosmetic will require review of ALL of the following clinical information and documentation, and such other documentation as may be reasonable requested:

A. Contemporaneous physician office notes with the history of the medical condition(s) requiring treatment or surgical intervention. This documentation must include **ALL of the following:**

1. The patient has venous insufficiency and valvular reflux that is consistent with the nature of the complaint that results in a functional impairment that is recurrent or persistent in nature **AND**

2. The condition is causing the functional impairment (include the nature of the impairment)

A. A written report, signed by the physician who interpreted the venous ultrasound study, utilizing B-mode imaging, spectral Doppler and color flow, performed with the patient standing or in reverse

[redacted]

Trendelenburg position, demonstrating reflux, duration of reflux, and documentation of vein size. Continuous wave hand-held Doppler is insufficient for these purposes. The function of the deep venous system should be addressed.

B. Documentation in physician office notes clearly showing skin changes or ulceration that may account for the functional impairment. High color quality photographs detailing dermatological changes may be requested as part of the documentation.

C. Treatment plan that must include proposed procedures (include CPT codes mapped to specific venous anatomic structures, and the expected outcome for the improvement of the functional deficit

ADDITIONAL INFORMATION: ***All required documentation must be submitted and approved through the standard process.***

II. Criteria for a Coverage Determination as Reconstructive:

REVIEW NOTES:

- Each of the requested surgical excisions or catheter entry points should be reviewed independently for coverage.

- **This policy does not address stab phlebectomy or sclerotherapy or other procedures not addressed in the Coding Section of this policy.**

A. Varicose vein treatments (radiofrequency ablation, endovenous laser ablation, stripping, ligation and excision) for the great saphenous vein, small saphenous vein or principle branches are considered reconstructive when all of the following criteria are present. The plan can include either single or combination treatments. Only one procedure code submitted per named vein will be considered for each vein:

[redacted]

1. Condition is caused by venous insufficiency.

2. Vein size by ultrasound:

    a. If the planned ablation involves the great saphenous vein, the vein must be 5.5 mm or greater in transverse diameter, as measured by duplex ultrasonography below the saphenofemoral junction (not valve diameter)
    b. If the planned ablation involves the small saphenous vein, the vein must measure 5 mm or greater in diameter just below the saphenopopliteal junction.
    c. If the planned ablation involves the named principal branches, the vein must measure 5 mm in diameter or greater.

    (Note; repeat studies/images submitted for evaluation must be time and date stamp and confirm that repeat measurements were taken at the same level as the initial report)

    d. If there is either bleeding or ulceration related to the varicose vein in question that has moderate or severe reflux as noted below, then vein sizes of lower diameters will be accepted.

3. Documentation in a signed report of duration of reflux, as measured by Spectral Wave Form study, in the standing or reverse Trendelenburg position that meets the following parameters:

    a. Greater than or equal to 500 milliseconds (ms) for the great saphenous, small saphenous or principle branches.
    b. Perforating veins ≥ 350 ms
    c. Some duplex ultrasound readings will describe this as moderate to severe reflux which will be acceptable.

[redacted]

4. Member must have one of the following functional impairments or treatments documented in the contemporaneous office notes and submission of the planned procedure(s) include CPT codes per venous system, i.e. which extremity(s), venous system(s) and procedures(s) planned per vein. **(skin changes must be documented with high quality color photography with patient ID)**:

    a. Skin ulceration **OR**
    b. Documented episode(s)s of frank bleeding of the varicose vein due to erosion of or trauma to the skin **OR**
    c. Documented superficial thrombophelbitis or documented venous stasis dermatitis **(high quality color photography documenting noted skin changes, with patient ID, may be requested) OR**
    d. Moderate or severe pain causing limitation of activities and if done, the documentation of a trial of compression hose that supports the relief of extremity pain and improved function

(Exhibit B, pages 2-3)

These criteria are consistent with the Medicaid standard of coverage to provide only medically necessary endovenous laser ablation treatments, do not effectively avoid providing medically necessary services and are allowable under the DCH-MHP contract provisions.

In the present case, the MHP initially denied the request after reviewing the information from the doctor because some information was missing or did not meet the rules. It was noted that the MHP needs to see: the duplex report, the formal reading of the report, that the vein size meets the rules for veins to be done, what skin problems the Appellant has because of the large veins, how those cause a functional problem, and what activities are limited because of the large veins. (Exhibit A) For example, under the above criteria, if the planned ablation involves the great saphenous vein, the vein must be 5.5 mm or greater in transverse diameter, as measured by duplex ultrasonography below the saphenofemoral junction (not valve diameter) or if the planned ablation involves the small saphenous vein, the vein must measure 5 mm or greater in diameter just below the saphenopopliteal junction. The [redacted] bilateral lower extremity venous duplex results show the Appellant's right great saphenous vein diameter was 4

[redacted]

mm, the left great saphenous vein diameter was 5 mm, the right small saphenous vein was 3 mm and the left small saphenous vein was 4 mm. (Exhibit C, page 6) The vein sizes documented in the [redacted] report were not sufficient to meet the MHP's criteria.

However, after the request for hearing was filed, the MHP's Medical Director reviewed the Appellant's request and medical records. The MHP's Medical Director recommended the Appellant get a second opinion by an in network specialist, and if the second opinion concurs that surgery is necessary, the MHP would approve payment. (Hearing Summary and Interim Plan Director Testimony)

On [redacted], the Appellant saw an in network specialist for a second opinion. This specialist wanted a baseline venous Doppler. (Exhibit D) On [redacted] a Bilateral Lower Extremity Venous Duplex Evaluation with Reflux Testing was completed. This report documents the Appellant's right great saphenous vein diameter was 3.8 mm and the left great saphenous vein diameter was 4.3 mm. (Exhibit E) The vein sizes documented in the [redacted] report were not sufficient to meet the MHP's criteria.

Further, the Appellant has had two additional evaluations by the second opinion specialist. On [redacted] it was noted: the Appellant continues to have complains of heaviness in both lower extremities; the recent venous Doppler does not show any great saphenous venous insufficiency and while she has multiple spider veins there is no obvious venous reflux; the specialist recommended the Appellant continue to wear compression stoking and would be getting a new pair. The specialist planned to evaluate how the Appellant's heaviness does in the next month or so as she wears the new compression stockings. (Exhibit F) On [redacted] the Appellant was re-evaluated. This office note states:

> At this time, she continues to have pain in her legs bilaterally with heaviness, numbness and tingling. Once again, we discussed that numbness and tingling is rarely symptom of venous disease and her recent venous Doppler did not show any reflux although it did show some varicosities in some reticular veins. These did not appear to be a source of significant disease and she notes that she has not been completely compliant to this point with the stockings. Once again, I have urged her to wear them daily and she notes that she will do so. I would like to follow up with her in two months' time. If at that point, she is still having problems, we will repeat the venous Doppler to see if we can identify any significant reflux.

(Exhibit G)

The Appellant testified that she is worried about getting worse and not getting better. (Appellant Testimony)

[redacted]

The documentation submitted for this prior authorization request was insufficient to establish the medical necessity of the requested endovenous laser ablation treatment. Neither venous Doppler report documented vein sizes sufficient to meet the MHP's criteria. Further, the reports from the second opinion specialist have not supported the medical necessity for the requested procedure thus far. The MHP's determination must be upheld.

If with further evaluation a treating doctor feels endovenous laser ablation treatment, other any other treatment(s) requiring prior authorization are needed, a new prior authorization request with documentation supporting the medical necessity of the requested service can always be submitted.

DECISION AND ORDER

The ALJ, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for endovenous laser ablation treatment based on the available information.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

/s/

Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

CL/db

cc: [redacted]

[redacted]

***** 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.