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:

[redacted],

Appellant

Docket No. 2013-9139 QHP
Case No. [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, [redacted], appeared on her own behalf. [redacted], Inquiry Dispute Appeals Resolution Coordinator, represented [redacted] of Michigan, the Medicaid Health Plan (hereinafter MHP). [redacted], Medical Director, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for hysterectomy surgery?

FINDINGS OF FACT

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

1. The Appellant is a [redacted]-year-old female Medicaid beneficiary who is enrolled in the Respondent MHP, Molina Healthcare of Michigan. (Exhibit 1, page 5)

2. On or about [redacted], the MHP received a prior authorization request for a total hysterectomy from the Appellant's doctor. The request indicated diagnoses of mass, pelvic pain, and fibroids. Emergency room records from [redacted] were attached, including ultrasound and CT reports. (Exhibit 1, pages 5-17)

3. On [redacted] the MHP sent the Appellant and her doctor's office a denial notice, stating that the request for hysterectomy surgery was not authorized based on the InterQual criteria because the submitted

information did not include a pap smear report (done within the last year) or documentation of work-up for pelvic pain. (Exhibit 1, pages 18-21)

4. On [redacted], the Appellant's Request for Hearing 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 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 (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. 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.
>
> *Section 1.022(E)(1), Covered Services.*
> *MDCH contract (Contract) with the Medicaid Health Plans,*
> *October 1, 2009.*

> (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.

(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.

Section 1.022(AA), Utilization Management,
MDCH contract (Contract) with the Medicaid Health Plans*,*
October 1, 2009.

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) states:

SECTION 12 – SURGERY – GENERAL

Medicaid covers medically necessary surgical procedures.

Michigan Department of Community Health
Medicaid Provider Manual;
Practitioner Version Date: July 1, 2012, Page 57

> **13.4 HYSTERECTOMY [RE-NUMBERED 4/1/12]**
> Hysterectomies are covered only if the beneficiary has been informed orally, prior to surgery that a hysterectomy will render her permanently incapable of reproducing. The beneficiary or her representative must sign a written acknowledgment of receipt of that information. The Acknowledgment of Receipt of Hysterectomy Information (MSA-2218) serves as the written acknowledgment.
>
> All items on the MSA-2218 must be completed and the form must be signed by the beneficiary (or representative) and the physician (MD or DO).
>
> Federal regulations prohibit Medicaid coverage for hysterectomies performed solely for the purpose of sterilization. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications, which alone do not indicate a hysterectomy.
>
> *Michigan Department of Community Health*
> *Medicaid Provider Manual;*
> *Practitioner Version Date: July 1, 2012, Page 63*

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

The MHP utilized the InterQual 2012 Procedures Adult Criteria Hysterectomy, Total Laproscopic (TLH), +/- BSO ("InterQual Criteria") when reviewing the Appellant's prior authorization request. Specifically, when the procedure is indicated for fibroids in premenopausal woman:

> INDICATION(S)
>
> 100 Fibroids in premenopausal woman
> _____
>
> 100 Fibroids in premenopausal woman **[All]**
> 110 Diagnosed by US
> 120 Findings **[One]**
> 121 Abnormal bleeding **[Both]**
> -1 Vagina and cervix normal by PE
> -2 Continued abnormal bleeding **[One]**
> A) Interferes with ADLs

B) Hct < 27% (0.27) / Hb <9.0 g/dL (90 g/L) unresponsive to iron Rx >12 wks
122 Uterine size doubled by US w/in 1 yr
123 Ureteral compression by US/IVP
124 Other associated symptoms **[One]**
-1 Pelvic/abdominal pain/discomfort w/o other explanation
-2 Urinary frequency/urgency w/o evidence of infection
-3 Dyspareunia
130 PAP smear normal w/in last yr
140 Pregnancy excluded **[One]**
141 HCG Negative
142 Sterilization by Hx
143 Patient not sexually active by Hx

(Exhibit 1, page 2)

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

The MHP determined that the documentation submitted for the prior authorization request did not meet the InterQual Criteria. The documentation submitted did not show a normal pap smear within the last year. The submitted documentation also failed to establish that the criteria addressing abnormal bleeding, uterine size doubled by within the last year, ureteral compression or other associated symptoms were met. The Medical Director explained that the pap smear is to be sure the uterus being removed is not cancerous. The documentation did not indicate abnormal bleeding or ureteral compression issues. The only documentation submitted was from an [redacted] emergency room visit. Accordingly, there was no documentation to establish uterine size doubling within the last year or that other causes of the abdominal pain were excluded. (Medical Director Testimony and Exhibit 1, pages 5-17)

The Appellant disagrees with the denial and indicated she underwent the requested hysterectomy on or about [redacted]. The Appellant testified that she had abdominal pain for the last three years and described going to see several different doctors and the testing/procedures she has had during that time. (Appellant Testimony) However, no documentation of the three year history was submitted with this prior authorization request. Additionally, the Medical Director stated that the MHP has not received a claim for the [redacted] hysterectomy. (Medical Director Testimony)

The documentation provided with the prior authorization request did not establish that the Appellant met the InterQual Criteria for prior approval of hysterectomy surgery. The

InterQual Criteria require a normal pap smear within the last year and specific findings regarding abnormal bleeding, uterine size doubling within the last year, ureteral compression, or other associated symptoms. The only medical documentation submitted was the [redacted] emergency room records, which did not identify abnormal bleeding, uterine size doubling within the last year, or ureteral compression. Further the [redacted] records were not sufficient to meet the criteria regarding other causes of the other associated symptoms. While the records documented abdominal pain, there was insufficient documentation of work up to exclude other causes. Medical necessity of the requested procedure was not established based on the information available to the MHP when they reviewed the Appellant's prior authorization request. Accordingly, the MHP's denial was proper based on the information available at that time.

As discussed during the telephone hearing proceedings, the Appellant's doctor can submit additional supporting documentation to the MHP for consideration.

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 hysterectomy surgery based on the submitted information.

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

\s\

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

cc: [redacted]

Date Mailed: 1/15/2013

***** 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.