

**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. 2013-30830 QHP

██████████,

██████████

Appellant

\_\_\_\_\_ /

**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 ██████████ and continued on ██████████. The Appellant appeared and testified on her own behalf. ██████████ was present but did not take part in the hearing. ██████████ represented ██████████, the Medicaid Health Plan (MHP). ██████████, RN Case Manager, and ██████████ Plan Medical Director, appeared as witnesses for the MHP. ██████████, from the ██████████ of the MHP, provided translation.

**ISSUE**

Did the MHP properly deny the Appellant's request for septoplasty and rhinoplasty?

**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 was enrolled in the Respondent MHP, ██████████ from ██████████ through ██████████ (Exhibit A, pp. 1-2).
2. On or about ██████████ the MHP received a request for septoplasty and rhinoplasty for the Appellant. (Exhibit B, pp. 2-5).
3. On ██████████, the MHP sent the Appellant a denial notice, stating that the request for septoplasty and rhinoplasty 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: for rhinoplasty, that the beneficiary has a cleft

problem, otherwise the procedure is cosmetic and nor covered; for septoplasty, the beneficiary must have nose problems that affect daily function, it must not have responded to good medical treatment, must have chronic sinusitis, must provide a CT and/or high quality photos showing the problem. Nasal blockage or congestion does not meet the MHP's criteria. (Exhibit A, p. 3).

4. On ██████████, the Appellant's Request for Hearing was received by the Michigan Administrative Hearing System. (Exhibit #1).

### **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 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/EPSTD 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.
- (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: January 1, 2013, Page 58*

### **13.3 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.

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: January 1, 2013, Page 64.*

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviewed this prior approval request under the ██████████) Coverage Determination Guideline for septoplasty and rhinoplasty. (Exhibit B, pp. 6-15). In part, the guidelines require the Appellant's provider to provide documentation to establish the prior authorization request meets the criteria for a reconstructive coverage. The guidelines provide in part that for a prior authorization request for rhinoplasty the documentation from the Appellant's physician must show that the Appellant has a cleft problem; otherwise the surgery is considered to be for cosmetic purposes and not covered by the ██████ guidelines. (Exhibit B, p. 9). In this case the Appellant's provider provided no such documentation to show the request met the criteria for reconstructive coverage.

As for the request for septoplasty, ██████ established that the guidelines provide in part that for a prior authorization request it must be established that the Appellant has a functional problem that needs to be addressed with the surgery; otherwise the surgery is considered cosmetic surgery and not covered by the ██████ guidelines. In this case the Appellant's provider provided no such documentation to show the request met the criteria for reconstructive coverage. The denial cited the lack of documentation from the Appellant's provider to show that the Appellant's problem had affected her daily function; that the Appellant had not responded to good medical treatment; that the Appellant had chronic sinusitis; there was no CT showing a the existence of a functional problem, and, there were no high quality photos submitted showing ██████ the problem. (Exhibit B, pp. 8-9).

Despite the lack of documentation with the prior authorization request, the MPH's Medical Director ██████████ stated that after they received the Appellant's hearing request, he consulted with the Appellant's provider, ██████████ and advised that the MPH would reconsider the denial if a CT scan were done showing a functional problem that would support their request for reconstructive surgery. ██████████ stated that despite his offer to the Appellant's provider, to his knowledge the Appellant failed to appear for a scheduled CT scan, and no such documentation has ever been presented to the MPH to show that the Appellant has a functional problem requiring reconstructive surgery.

The documentation submitted for this prior authorization request was insufficient to establish the medical necessity of the requested surgeries, i.e., septoplasty and rhinoplasty. The MHP's determination must be upheld.

### **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 septoplasty and rhinoplasty based on the available information.

[REDACTED]  
Docket No. 2013-30830 QHP  
Decision and Order

**IT IS THEREFORE ORDERED** that:

The Medicaid Health Plan's decision is **AFFIRMED**.

*William D Bond*

William D. Bond  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

WDB/db

cc: [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.