

**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. 2013-40711 QHP
Case No. [REDACTED]

[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], legal department, represented the Medicaid Health Plan (MHP). Her witness was Dr. [REDACTED], M.D. [REDACTED] Plan, medical director.

ISSUE

Did the MHP properly deny the Appellant's request for prior authorization (PA) of 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] Plan.
2. On or about [REDACTED], the MHP received a request for bilateral endovenous laser ablation to relieve "pain and other problems." (Respondent's Ex. A, Sub A)
3. The Appellant complains of leg discomfort, varicose veins, leg aching - worse in the evening - swelling, pain, restless leg, itching, throbbing and discoloration. (Respondent's Ex. A, Sub E)
4. The Appellant's physician reported an "incompetent medial branch in the right thigh" which was not referenced or further explained during the supine venous insufficiency exam. (Respondent's Ex. A, Sub F)

5. On ██████████, the MHP sent the Appellant a denial notice, stating that the request for vein surgery was denied noting the doctor needed to show recent use of simple treatments and that her vein sizes were not large enough. (Respondent's Ex. A, Sub A)
6. On ██████████, 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 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 (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:

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- 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 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,
July 1, 2012, page 57

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.

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.

Supra, page 63.

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

○ **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 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 requires 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:

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 \geq 350 ms

- c. Some duplex ultrasound readings will describe this as moderate to severe reflux which will be acceptable.
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) 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

(Respondent's Ex. A, Sub B)

In this case the MHP has denied the Appellant's request following review by Dr. ██████████ and Dr. ██████████ – both medical directors at ██████████. Essentially, Dr. ██████████ observed that the necessary baseline vein incompetence measurements were not at standard or not supplied and that there was no evidence to establish that conservative treatment – elevation and OTC pain medications - had not been successful.

The Appellant testified that the procedure was necessary because she "...was on [her] feet 24/7." She said she had pain and sensitivity to touch. She added that compression stockings were "...not the long term answer."

On review, the evidence submitted for this prior authorization request was insufficient to establish the medical necessity of the requested laser ablation treatment for both legs. Specifically, the criteria regarding documentation of functional impairments, trial with

[REDACTED]
Docket No. 2013-40711 QHP
Decision And Order

compression hose, and vein size were not met – and importantly the omission of the measurement or reference to the medial branch noted in Finding of Fact #4. [above] The MHP's determination must be upheld.

The Appellant failed to preponderate her burden of proof. The Respondent MHP properly denied the request for PA of laser ablation treatment.

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 laser ablation treatment based on the documentation presented for evaluation.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

 \sl
Dale Malewska
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[REDACTED]
cc: [REDACTED]

Date Signed: 7/8/2013

Date Mailed: 7/8/2013

***** 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.