

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. 2013-43323 QHP
Case No. ██████████

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 ██████████. The Appellant appeared without representation. She had no witnesses. The MHP ██████████ [██████████] was represented by ██████████, appeals coordinator. Her witness was ██████████, R.N.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for bilateral breast reduction?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. At the time of hearing the Appellant is a ██████████ female Medicaid beneficiary. Appellant's Exhibit 1
2. The Appellant is enrolled in the McLaren Health Plan of Michigan. She has been a member since ██████████ 010.
3. On ██████████, the MHP received a request [with supporting documentation] for bilateral breast reduction from Dr. ██████████. Respondent's Ex. A – summary
4. On ██████████ the MHP contacted the physician's office for additional information [photographs] which were already en route. Respondent's Ex. A – summary

5. On ██████████ the MHP medical director reviewed the request and made the decision to deny as the documentation submitted did not show excessively large breasts, bra strap grooving, or a skin rash. Furthermore the Appellant's pharmacy profile did not show use of medication to treat rash or pain. Respondent's Ex. A – summary and See Testimony.
6. Denial letters were mailed to both Appellant and her physician on ██████████. Respondent's Ex. A – summary and attachment B.
7. The Appellant's further appeal information was contained therein. Respondent's Ex. A, attachment B
8. The Appellant alleged anxiety and depression as a result of her breast size – in addition to pain and discomfort. Appellant's Ex. 1 and See Testimony
9. The instant appeal was received by the Michigan Administrative Hearing System for the Department of Community Health on ██████████. Appellant's 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 Medicaid Health Plans.

The Respondent 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 but may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of an enrollee. In general, the Contractor is responsible for covered services related to the following:

- The prevention, diagnosis, and treatment of health impairments
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain, or regain functional capacity

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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 (only for enrollees under 21 years of age)
- 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 in accordance with Medicaid policy as stated in the Medicaid Provider Manual, Mental Health/Substance Abuse Chapter, Beneficiary Eligibility Section
- 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

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- 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

Contract §1.020 Scope of [Work and Deliverables],
at §1.022 E (1) 2013, p. 22 *et seq*

Additionally, the MHPs are restricted by contract and the MPM from providing the service of elective cosmetic surgery.¹ The criteria for approval of cosmetic procedures under the MPM are exacting:

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. (Emphasis supplied)

MPM, Practitioner, §13.3, July 1, 2013, page 66.²

¹ See MPM, Medicaid Health Plans, §1.3

² Renumbered from previous [13.2 identical] version.

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At hearing the MHP witness testified that the Appellant's weight was 215 pounds and her height 5' 6". She said while the Appellant's breasts were considered "dense" on review with the medical director the MHP did not find them to be out of proportion to her height and weight. Additionally, there was no observable shoulder grooving in the photographs sent in for review.

The Appellant had no questions, at hearing, but said she has pain in her back and cannot exercise. She said her rash is persistent – although she documented her ongoing treatment for that condition in her petition.

The MHP witness said that their decision was based on information received at the time of the request and she advised the Appellant that should new or aggravating issues develop to contact her physician.

Owing to her youth and otherwise good health the Appellant did not present with the type of evidence that would satisfy the MHP clinical review standards. There was inadequate evidence to cause a medical evaluator to investigate further for proof of medical necessity.

The Appellant has not preponderated her burden of proof.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for breast reduction surgery.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

ls

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

cc: [REDACTED]

Date Signed: 7/26/2013

Date Mailed: 7/23/2013

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***** 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.