

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. 2013-54623 QHP

██████████,

██████████

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 telephone hearing was held on ██████████ ██████████
██████████ mother, represented the Appellant.

Priority Health was represented by ██████████ Manager of Medicaid Products. Priority Health is a Department of Community Health contracted Medicaid Health Plan ("MHP").

ISSUE

Did the MHP properly deny the Appellant's request for labiaplasty with removal of excessive tissue?

FINDINGS OF FACT

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

1. The Appellant is a ██████-year-old Medicaid beneficiary who is currently enrolled in the Respondent MHP, Priority Health. (Exhibit A)
2. On or about ██████████ the MHP received a request for authorization for an ██████████ labiaplasty with removal of excessive tissue surgery for the Appellant listing a diagnosis of left sided labial hypertrophy. (Exhibit A)
3. On ██████████, the MHP issued a letter to the Appellant indicating the request was denied based on the information provided. The letter indicated that under the MHP's medical policy a vulvectomy, an excision for labial hypertrophy, is not a covered benefit. The letter also noted that under the Medicaid Provider Manual policy, unless there was retroactive

eligibility, a request for retroactive prior authorization of services will be denied. (Exhibit B)

4. On ██████████ the Appellant's request for hearing was received by the Michigan Administrative Hearing System. (Hearing Request)

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. 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

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- 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:
 - 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.

....

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:

1.9 PRIOR AUTHORIZATION [RE-NUMBERED 4/1/13]

Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services.

*Michigan Department of Community Health
Medicaid Provider Manual;
Practitioner Version Date: April 1, 2013, Page 4*

SECTION 12 – SURGERY – GENERAL

Medicaid covers medically necessary surgical procedures.

*Michigan Department of Community Health
Medicaid Provider Manual;
Practitioner Version Date: April 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: April 1, 2013, Page 64*

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviewed the prior approval request under the MHP's Medical Policy for Skin Conditions. (Exhibit C) In part, the Medical Policy states:

10. Labial hypertrophy: excision of excessive skin and subcutaneous tissue for hypertrophy of the labia is not a covered benefit.

8. Treatment of Labial Hypertrophy – Not Covered

CPT/HCPCS Codes

15839 Excision, excessive skin and subcutaneous
 tissue (includes lipectomy); other area
56620 Vulvectomy simple; partial

Services billed with these diagnoses are not covered.

ICD-9 Codes (for dates of service on or before September 30, 2014):

624.3 Hypertrophy of labia

ICD-10 Codes (For dates of service on or after October 1, 2014):

N90.6 Hypertrophy of Vulva

(Exhibit C, pages 6 and 13 of 14)

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

The MHP asserts that the Appellant did not meet the medical necessity criteria found in the above cited Medical Policy because coverage is excluded for the specific diagnosis of labial hypertrophy. The MHP further noted that this was a retroactive prior authorization request. Accordingly, the Appellant should not be receiving bills for a service the provider failed to obtain prior authorization for. (Exhibits A-C; Director of Medicaid Products Testimony)

The Appellant's mother disagrees with the denial and testified this was medically necessary procedure for the Appellant and was not cosmetic. The Appellant had been having a lot of urinary tract infections, and even underwent bladder and kidney testing. The Appellant was understandably embarrassed to discuss this problem with her mother or doctor. The Appellant has not had another infection since the procedure. Further, the doctor told the Appellant's mother that they had to send the prior authorization request back through because it was denied the first time, but then it went through. The Appellant's mother confirmed that they have not been billed by the doctor or hospital for the procedure. (Mother Testimony)

