

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. 2013-65313 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 ██████████ ██████████ son, represented the Appellant and provided interpretation. ██████████, the Appellant, appeared and testified. ██████████ Paralegal, represented ██████████, the Medicaid Health Plan (MHP). ██████████ Medical Director, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for sclerotherapy?

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, ██████████
2. On ██████████, the MHP received a request for sclerotherapy for the Appellant for a diagnosis of varicose vein with complications. (Exhibit C)
3. On ██████████ the MHP sent the Appellant a denial notice, stating that the request for sclerotherapy was denied under the MHP's rules. The MHP need to see that these large veins caused an ulcer or that the Appellant has had significant bleeding from them. The MHP needed to see that the Appellant has unfixable large veins from an abnormal group of blood vessels. (Exhibit A)

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 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 1 – GENERAL INFORMATION

This chapter applies to physicians (MD, DO), Oral-Maxillofacial Surgeons, Doctors of Podiatric Medicine (DPM), Medical Clinics, Physical Therapists (PTs), Certified Nurse-Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), Anesthesiologist Assistants (AAs), and Nurse Practitioners (NPs).

Generally, medically necessary services provided to a Medicaid beneficiary by an enrolled practitioner are covered.

* * *

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: July 1, 2013, Pages 1 and 4.*

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviewed this prior approval request under the plan rules, MCG Ambulatory Care, 17th Edition, Sclerotherapy, Leg Veins. (Exhibit B) In part, the guidelines state local infection is an absolute contraindication to leg vein sclerotherapy. (Exhibit B, page 1) The criteria and clinical indications are:

Criteria

For postprocedure or adjunctive treatment of varicose veins, a systematic review comparing the safety and efficacy of varicose vein treatments stated that sclerotherapy is more appropriate for patients with minor superficial varicose veins not related to reflux of the saphenous system or as a postprocedure or adjunctive treatment to surgery. A systematic review concluded that the evidence supports the use of sclerotherapy as limited to the treatment of recurrent varicose veins following surgery and thread veins.

For skin ulcers, a study of 29 patients with active venous skin ulcers treated with foam sclerotherapy reported healing or improvement in 93% of ulcers. An evidence-based specialty society guideline suggested treatment of perforating veins greater than 3.5 mm located underneath active or healed ulcers.

For saphenous vein incompetence, studies have demonstrated that when sclerotherapy is used alone, 40% to 80% of patients will experience a recurrence of incompetence at 5 years. A systematic review comparing sclerotherapy alone with surgery for saphenous vein incompetence concluded that at 1 year, outcomes, including treatment success, complication rate, and cost were better for sclerotherapy than for surgery; however, at 5 years, surgical outcomes were better than those for sclerotherapy. An evidence-based specialty society guideline recommended endovenous thermal ablation (radiofrequency or laser) over foam sclerotherapy for treatment of saphenous vein incompetence.

For varicose veins, an evidence-based specialty society guideline recommended against selective treatment of perforating vein incompetence in patients with simple varicose veins. A systematic review of foam sclerotherapy for treatment of greater or lesser saphenous varicose veins concluded that, based upon complete occlusion rates, foam sclerotherapy was less effective than surgery. A 4-way randomized trial comparing ultrasound-guided foam sclerotherapy, endovenous laser ablation, radiofrequency ablation, and surgical stripping for the treatment of greater saphenous varicose veins concluded that, although associated with fast recovery and less postoperative pain, ultrasound-guided foam sclerotherapy was the least technically effective of these techniques.

Clinical Indication for Procedure

- Leg vein sclerotherapy may be indicated for **1 or more** of the following
 - Bleeding or ruptured superficial varicose veins, and need for emergency treatment
 - Recurrent or residual symptomatic superficial varicosities after vein stripping or ablation

- Skin ulcer with surrounding large superficial varices, when not associated with saphenofemoral valve incompetence
- Symptomatic superficial varices for which surgery is not advisable

(Exhibit B, pages 1-2)

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

In the present case, the denial notice indicates the MHP denied the request for sclerotherapy because the submitted information did not show that the Appellant's large veins caused an ulcer or that she has had significant bleeding from them. Further, the MHP did not see that the Appellant has unfixable large veins from an abnormal group of blood vessels. (Exhibit A)

The MHP's Medical Director testified that the submitted information did not show a size or degree of vein incompetence to meet the criteria nor specific skin changes typically indicating for the sclerotherapy (such as bleeding or ruptures of the varicose veins, super varicosities after another procedure, ulcers of the skin around varicose vein). Further, the submitted documentation and testimony regarding the skin changes, pain and swelling the Appellant has may relate to diabetes. Diabetes affects the very tiny blood vessels, and those changes do need to be addressed, but not with vein surgery. The ██████████ clinical note documents cellulitis, an infection, in the lower extremity. With diabetes these infections are common and may be cause pain. The Medical Director summarized that the criteria for the vein surgery is not met and focusing on the vein surgery may delay other areas needing care. Additionally, doing the sclerotherapy in the area of the infection could bring the infection deeper into the system. (Medical Director Testimony) The MHP further indicated they would be able to assist the Appellant is connecting with another specialist.

The Appellant disagrees with the denial and testified she has successfully had this surgery before. The Appellant knows her body. Now it has come up again with another vein. The Appellant has a lot of pain and cannot walk. The Appellant is supposed to walk a lot because of her diabetes. The Appellant acknowledged that she had an infection and testified that she no longer has an infection. The Appellant understands the Medical Director's concern. With diabetes it is easy to get infections and potentially this could cause her to lose her legs. (Appellant Testimony)

The documentation submitted for this prior authorization request was insufficient to establish the medical necessity of the requested sclerotherapy at this time. The submitted clinical documentation did not show clinical indications regarding bleeding/ruptures or ulceration were met. The second the clinical indications for the

procedure is "Recurrent or residual symptomatic superficial varicosities after vein stripping or ablation." The documentation does state there is evidence of prior vein stripping of the right great saphenous vein and small saphenous vein. The documentation also indicates current varicosity associated with the right great saphenous vein at its mid segment. The documentation further indicated the Appellant has pain. However, the plan rules are clear that sclerotherapy is contraindicated with a local infection. The [REDACTED] note indicates cellulitis in the right lower extremity and an antibiotic prescription. The Medical Director testified that the Appellant's symptoms could be caused by this type of infection, which is common with diabetes and can be chronic. (Exhibits B and C; Medical Director Testimony) The MHP's determination must be upheld in light of the documentation indicating treatment for a local infection.

As noted during the hearing proceedings, a new prior authorization request with additional documentation supporting the medical necessity of the requested service for the Appellant can be submitted. For example, documentation may be submitted showing that the Appellant no longer has an infection, her symptoms are continuing and are clearly related to varicose veins.

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 sclerotherapy based on the available information.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

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

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

CL/db

cc: [REDACTED]

[REDACTED]
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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.