

**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:

████████████████████

Appellant

Docket No. 2013-66647 QHP
Case No. ██████████

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge 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 November 26, 2013. Appellant was represented by ██████████. The Medicaid Health Plan (MHP), ██████████ was represented by ██████████, Paralegal. ██████████ appeared as a witness for the MHP.

ISSUE

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

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. Appellant is a ██████ year-old Medicaid beneficiary, born ██████████. (Exhibit 1, p 1)
2. On or about ██████████, the MHP received a Prior Authorization Request from ██████████ on behalf of Appellant for surgery described as "...a septoplasty and bilateral partial inferior turbinectomies". (Exhibit C, pp 1-3) Appellant's diagnoses are 470 and 478.0. (Exhibit A) Petitioner's surgeon's evaluation indicates that that Petitioner's nasal airflow is reduced to approximately 5-10% of predicted normal on the right and approximately 60% of predicted normal on the left, and that Appellant has a severely deviated cartilaginous deformity involving the caudal septum from left to right with sharply angulated edges. (Exhibit C, p 1)
3. On ██████████, the MHP advised Appellant that his request for outpatient nose surgery was denied because the MHP determined, based

on the documentation submitted, that Petitioner did not submit evidence to show that the surgery met the “medically necessary” criteria as required by the MHP’s Coverage Determination Guideline for Rhinoplasty, Septoplasty and Repair of Vestibular Stenosis. (see Exhibit B)

4. On ██████████, Appellant filed a Request for Hearing with the Michigan Administrative Hearing System (MAHS). (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 MHP signs a contract with the State of Michigan identifying certain services that are required. The applicable contract to the facts herein states in part:

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/EPSDT 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].

Under its contract with the Department, an MHP may devise criterion for coverage of medically necessary services, as long as those criterion do not effectively avoid providing medically necessary services. An MHP must also provide its members with the same or similar services or medical equipment to which fee-for-service beneficiaries would otherwise be entitled under the Medicaid Provider Manual.

Fee for Service Medicaid beneficiaries have limited access to surgical procedures. Septoplasty surgery falls within the Medicaid Provider Manual policy governing general surgery, set forth below:

SECTION 12 – SURGERY – GENERAL

Medicaid covers medically necessary surgical procedures.

*Michigan Department of Community Health
Medicaid Provider Manual; Practitioner*

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.”

In this case, the MHP submitted as Exhibit B UnitedHealthcare’s specific Coverage Determination Guideline applicable to the facts herein. The applicable portions state:

DOCUMENTATION FOR SEPTOPLASTY AND RHINOPLASTY:

- A. 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. Chief complaint in addition to the progression or recurrence of symptoms to include any failed surgical interventions or procedures; AND
 - 2. History of nasal symptoms requiring treatment or surgical intervention; AND
 - 3. Documentation of maximum medical therapy such as steroids, antibiotics, and nasal lavage, along with any specialty consultations; AND
 - 4. Results of an external nasal and intranasal evaluation.
- B. Clinical studies/tests addressing the physical and/or physiologic abnormality that confirm its presence and the degree to which it is causing impairment:
 - 1. Formal, signed computed tomography (CT) report of maxillo-facial/nasal sinus area documenting the degree of the septal deviation if available; OR
 - 2. Any other tests that document the septal deviation and/or external post traumatic nasal (bone) deformity including, but not limited to, radiologic evaluation using MRI, nasal endoscopy or photographs.
- C. Treating physician’s plan of care for the proposed procedures, which must include the expected improvement of the functional impairment.

ADDITIONAL INFORMATION: All required documentation must be submitted and approved through the standard review process.

- II. Criteria for a Coverage Determination that surgery is reconstructive ALL OF THE FOLLOWING MUST BE DOCUMENTED IN PHYSICIAN OFFICE NOTES

(A summary letter of medical necessity is not a substitute for physician office notes):

SEPTOPLASTY FOR NASAL OBSTRUCTION:

Documentation: See section I, Documentation for Septoplasty and Rhinoplasty. Criteria: Septoplasty is considered reconstructive when ALL of the following criteria are present (A through C):

A One of the following is required:

1. Obstructive sleep apnea as confirmed by a polysomnogram showing an apnea hypopnea index (AHI) of 5 or greater and intolerance to CPAP or APAP due to nasal obstruction caused by nasal septal deviation. When an AHI result is not available or reported, a respiratory disturbance index (RDI) of 5 or greater would also be acceptable; OR
2. Recurrent epistaxis secondary to the septal deformity; OR
3. Chronic sinusitis (see definition section below). The chronic sinusitis must have a history of >6 months in duration, OR, that the member has had recurrent acute sinusitis; OR
4. Consistent prolonged subjective difficulty breathing through the nose resulting in chronic mouth breathing and xerostomia.

B. Anatomic mechanical nasal airway obstruction with nasal septal deviation that is documented by an internal examination of the nose documenting septal deviation is causing an anatomic mechanical nasal airway obstruction and is the primary contributing factor of obstructed nasal breathing.

AND

C. Maximum medical therapy has failed, such as steroids, antibiotics, and nasal lavage, along with any specialty consultations.

SEPTOPLASTY FOR SEPTAL DEFORMITY THAT LIMITS ACCESS FOR ENDOSCOPIC SINUS SURGERY:

Documentation: See section I, Documentation for Septoplasty and Rhinoplasty. Repair of a septal deformity that limits access for endoscopic sinus surgery is considered reconstructive.

SEPTOPLASTY FOR NASAL/SEPTAL FRACTURE:

Documentation:

- A. See section I, Documentation for Septoplasty and Rhinoplasty, AND
- B. Endoscopic evaluation or photograph; OR
- C. High quality photograph(s) clearly demonstrating the degree of the post traumatic nasal septal deformity due to a nasal septal fracture. The service reference / identification number along with the patient's name and date of service must be included on the photograph.

Criteria:

Rhinoplasty, Septoplasty, and Repair of Vestibular Stenosis: Coverage Determination Guideline (Effective: May 1, 2013)

Repair of septal deviation due to a nasal/septal fracture that is causing an anatomic mechanical nasal airway obstruction and is the primary contributing factor for obstructed nasal breathing, is considered reconstructive. UnitedHealthcare Coverage Determination Guideline, CR-A-005; May 1, 2013 (Exhibit B)

As noted in the Findings of Fact, Appellant was denied because the verification did not comply with the verification required by the MHP's Plan. Appellant's physician's documentation of [REDACTED] did not show that all of the criteria submitted met the criteria required by all three-A, B, and C (cited above). Appellant and Appellant's representative expressed agreement that they now understand what verification is necessary to comply with the requirements of the Plan..

The purview of an Administrative Law Judge (ALJ) at an administrative hearing is to review the action taken, and, to make a determination if that action is correct under the parameters of the Plan (and not contrary to the Medicaid Policy and/or law). As the verification submitted by Appellant does not meet the requirements as laid out in the MHP contract, this ALJ must uphold the denial under these facts. Appellant understands that he may reapply.

[REDACTED]
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DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of the Appellant's request for a septoplasty was correct.

IT IS THEREFORE ORDERED that:

The MHP's decision is **AFFIRMED**.

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

[REDACTED]
cc: [REDACTED]

Date Signed: December 12, 2013

Date Mailed: December 13, 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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.