

**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. 14-006444 PA  
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.*, upon Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant appeared on her own behalf. ██████████, Appeals Review Officer, represented the Department. Dr. ██████████, Chief Medical Director, appeared as a witness for the Department.

**ISSUE**

Did the Department properly deny Appellant's prior authorization request for breast reduction surgery?

**FINDINGS OF FACT**

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

1. Appellant is a █████ year old Medicaid beneficiary, born ██████████. (Exhibit A, p 17; Testimony)
2. On or about ██████████, the Department received a prior authorization request from ██████████, for breast reduction surgery for Appellant. (Exhibit A, pp 14-20; Testimony)
3. On ██████████, the request for breast reduction surgery was reviewed by the Department's Chief Medical Director, who determined that Appellant did not meet the criteria for cosmetic surgery. (Exhibit A, p 10; Testimony)
4. On ██████████, the Department issued a Notification of Denial to the Appellant and the medical provider stating that the prior authorization

request was denied based on Section 8.3 of the General Information for Providers Chapter of the Medicaid Provider Manual because the request did not meet the criteria for cosmetic surgery. (Exhibit A, pp 8-9, 12; Testimony)

5. On ██████████, the Michigan Administrative Hearing System received Appellant's request for hearing. (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.

With regard to cosmetic surgery, the Medicaid Provider Manual provides, in pertinent part, as follows:

#### **8.3 NONCOVERED SERVICES**

The items or services listed below are not covered by the Medicaid program:

- Acupuncture
- Autopsy
- Biofeedback
- All services or supplies that are not medically necessary
- Experimental/investigational drugs, biological agents, procedures, devices or equipment
- Routine screening or testing, except as specified for EPSDT Program or by Medicaid policy
- Elective cosmetic surgery or procedures
- Charges for missed appointments
- Infertility services or procedures for males or females, including reversal of sterilizations
- Charges for time involved in completing necessary forms, claims, or reports

When the beneficiary needs a medical service recognized under State Law, but not covered by Medicaid, the service provider and the beneficiary must make their own payment arrangements for that noncovered service. The beneficiary must be informed, prior to rendering of service, that Medicaid does not cover the service. A Medicaid beneficiary in a nursing facility can use his patient-pay funds to purchase noncovered services

subject to MDCH verification of medical necessity and the provider's usual and customary charge. (Refer to the Nursing Facility Chapter for additional information.) (Emphasis added)

*Medicaid Provider Manual,  
General Information for Providers Chapter  
April 1, 2014, p 18*

### **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.

*Medicaid Provider Manual,  
Practitioner Chapter  
April 1, 2014, p 66*

The Department's Chief Medical Director testified that Appellant's prior authorization request indicated that she was seeking breast reduction surgery due to pain in her back, shoulder and neck due to her large breasts. The Department's Chief Medical Director indicated that breast reduction surgery is considered cosmetic surgery under the Medicaid Provider Manual and that cosmetic surgery is generally not covered, according to Section 8.3. The Department's Chief Medical Director indicated that there are exceptions to the exclusion found in Section 13.3 of the Practitioner Chapter of the Medicaid Provider Manual, but that Appellant did not meet any of the exceptions. Specifically, the Department's Chief Medical Director testified that pain can be considered a major health problem (one of the exceptions) but that Appellant's weight was a contributing factor to that pain, so the request was denied.

Appellant testified that she understands that her weight is an issue and that she has always been large. Appellant indicated that her doctor recommended weight loss and

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that her weight dropped from 246 pounds in ██████████ pounds in ██████████. Appellant also testified that she suffers from sleep apnea and her doctor believed that weight loss as well as breast reduction surgery could help with the sleep apnea. Appellant indicated that sleep apnea is a major health problem because she could stop breathing during sleep and die. Appellant also testified that in addition to sleep apnea and the pain in her back, neck and shoulders, she also suffers from high blood pressure and high cholesterol. Appellant testified that she is trying to improve her health and has done so by losing weight and quitting smoking. Appellant indicated that she walked 6 miles to get to the hearing.

Based on the documentation submitted, Appellant did not meet the Medicaid standards of coverage and documentation requirements to establish medical necessity for the requested breast reduction surgery. As indicated above, Medicaid policy generally does not cover cosmetic surgery and, based on the information available to the Department when its decision was made, Appellant did not meet any of the exceptions. While Appellant has now lost weight, that information was not available to the Department when it made its decision. Appellant's doctor indicated in the prior authorization request that Appellant was seeking breast reduction surgery due to pain in her back, neck and shoulders, and Appellant's weight in that documentation could have contributed to that pain. Furthermore, Appellant's doctor did not indicate in the prior authorization request that Appellant was seeking breast reduction surgery to help with her sleep apnea. Accordingly, the Department's denial must be upheld.


Appellant may wish to have her doctor resubmit a new prior authorization request identifying her recent weight loss and her issues with sleep apnea.

**DECISION AND ORDER**

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

**IT IS THEREFORE ORDERED** that:

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



Robert J. Meade  
Administrative Law Judge  
for Nick Lyon, Acting Director  
Michigan Department of Community Health

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cc:

RJM

Date Signed:

Date Mailed:

**\*\*\* 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.