

**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.: 14-012673 MHP  
Case No.: ██████████**

**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 Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant appeared on her own behalf. ██████████, Paralegal, represented ██████████, the Medicaid Health Plan (hereinafter MHP). ██████████, Medical Director, appeared as a witness for the MHP.

**ISSUE**

Did the MHP properly deny the Appellant's request for breast-reduction surgery?

**FINDINGS OF FACT**

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. Appellant is a ██████-year-old female Medicaid beneficiary who is currently enrolled in the Respondent MHP. (Exhibit A, p 16)
2. On ██████████, the MHP received a request for breast-reduction surgery from Appellant's physician. Appellant's physician noted that Appellant was complaining of shoulder pain, back pain, neck pain and exercise impairment. Appellant's physician noted that the Appellant did not suffer any pain in her breasts or from any skin irritation in the breast area. (Exhibit A, pp 14-42)
3. On ██████████, the MHP sent Appellant a denial notice, stating that the request for breast-reduction surgery was not authorized under the United Healthcare Guidelines because her essential life functions have not

been limited and there may be other causes for the Appellant's complaints. (Exhibit A, p 3; Testimony)

4. On ██████████, the Michigan Administrative Hearings System (MAHS) received the Appellant's request for hearing. (Exhibit A, p 12)

### **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 (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors 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 1-Z.

*Article II-G, Scope of Comprehensive Benefit Package.  
MDCH contract (Contract) with the Medicaid Health Plans,  
September 30, 2004.*

The major components of the Contractor's utilization management plan 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.

The Contractor must establish and use a written prior approval policy and procedure for utilization management 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 utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

*Article II-P, Utilization Management, Contract,  
September 30, 2004.*

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) states:

#### **SECTION 12 – SURGERY – GENERAL**

Medicaid covers medically necessary surgical procedures.

*Medicaid Provider Manual  
Practitioner Chapter  
July 1, 2013, p 61*

#### **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.

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- 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.

*Medicaid Provider Manual*  
*Practitioner Chapter*  
*July 1, 2013, p 67*

Under the DCH-MHP contract provisions, an MHP may devise their own criterion for coverage of medically necessary services, as long as those criterion do not effectively avoid providing medically necessary services.

The MHP utilized its Policy and Procedure Manual, Breast Reduction Surgery section, when reviewing Appellant's prior authorization request, which provides that Reduction Mammoplasty is covered if all of the following criteria are met:

- A. Macromastia is the primary etiology of the member's functional impairment or impairments AND
- B. The amount of tissue to be removed plots above the 22<sup>nd</sup> percentile; OR
- C. If the amount of tissue to be removed plots between the 5<sup>th</sup> and 22<sup>nd</sup> percentiles, the procedure may be either reconstructive or cosmetic; the determination is based on the review of the information provided; AND
- D. Diagnostic tests, if done, have ruled out other causes of the functional impairment; AND
- E. The proposed procedure is likely to result in significant improvement of the functional impairment.

(Exhibit A, pp 4, 5)

These criteria are consistent with the Medicaid standards of coverage for cosmetic surgery, do not effectively avoid providing medically necessary services and are allowable under the DCH-MHP contract provisions.

The MHP determined that the documentation submitted for the prior authorization request did not meet the above criteria. Specifically, documentation submitted did not show that macromastia was the primary etiology of the member's functional impairments AND diagnostic tests did not rule out other causes of the functional impairment.

