

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. 2014-32722 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.*, and upon the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant personally appeared and testified. Appellant was represented by ██████████.

██████████, Chief Clinical Officer, represented ██████████, the Respondent Medicaid Health Plan ("MHP"). ██████████, Grievance Coordinator, and Dr. ██████████, Medical Director, also testified as witnesses for Respondent.

ISSUE

Did the MHP properly deny Appellant's prior authorization request for surgery for gynecomastia?

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 an ██████ year-old male Medicaid beneficiary enrolled in the Respondent MHP.
2. Appellant has a history of gynecomastia, impotence related issues, asthma, obesity, and psychological related issues. (Exhibit A.15)
3. On ██████████ the MHP received a prior authorization request submitted on Appellant's behalf for surgical removal of excess breast tissue
4. Appellant has a history of taking Risperdal, a medication known to cause gynecomastia side effects. Appellant is currently is a class action lawsuit concerning this drug.

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5. A ██████████ ██████████ notes signed by Dr. ██████████, MD indicates that Appellant has had a weight loss of 65 pounds, starting weight of 319 and as of the date of the evaluation, weighing 254 pounds with a BMI of 36.4. (Exhibit 6)
6. On ██████████ and ██████████ PA's were submitted. On ██████████ and a subsequent internal review of ██████████ the requests were denied by the MHP.
7. On ██████████, the MHP issued a denial for surgical treatment for gynecomastia for the following reasons: documentation did not support that: the breast tissue is glandular and not fatty; that other causes have been ruled out including reversible drug treats when drugs can be discontinued; hormonal causes have not been excluded by appropriate laboratory testing; and that Appellant has not participated in a weight loss and exercise program for at least 6 months. (Exhibit 11) The notice of denial was based on the national criteria for Surgical Treatment for Gynecomastia contained in the MHP's Total Health Care Attachment D, pages 1-3 (Exhibit D)
8. On ██████████, the Michigan Administrative Hearing System (MAHS) received the Request for Hearing filed by Appellant in this matter.

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.

In 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 and, as provided in the Medicaid Provider Manual (MPM), is responsible for providing covered services pursuant to its contract with the Department:

The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology,

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Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix for website information.) MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The

following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

1.1 SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)

The following services must be covered by MHPs:

- Ambulance and other emergency medical transportation
- Blood lead services for individuals under age 21
- Certified nurse-midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services

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- Durable medical equipment and medical supplies
- Emergency services
- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing and speech services
- Hearing aids
- Home health services
- Hospice services (if requested by enrollee)

- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility) for up to 45 days
- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services
- Mental health care (up to 20 outpatient visits per calendar year)
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care
- Pharmacy services
- Podiatry services

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- Practitioner services (such as those provided by physicians, optometrists, or oral maxillofacial surgeons)
- Prosthetics and orthotics
- Therapies (speech, language, physical, occupational)
- Tobacco cessation treatments, including pharmaceutical and behavior support
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSTD for individuals under age 21

1.2 SERVICES EXCLUDED FROM MHP COVERAGE BUT COVERED BY MEDICAID

The following Medicaid services are not covered by MHPs:

- Custodial care in a licensed nursing facility; restorative or rehabilitative nursing care in a licensed nursing care facility beyond 45 days
- Certain dental services (Refer to the Dental chapter of this manual for additional information.)
- Specific injectable drugs administered through a PIHP/CMHSP clinic to MHP enrollees are reimbursable by MDCH on a fee-for-service basis. (Refer to the Injectable Drugs and Biologicals subsection of the Practitioner Chapter of this manual for additional information.)

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- Home and Community Based Waiver program services
- Inpatient hospital psychiatric services (MHPs are not responsible for the physician cost related to providing a psychiatric admission physical and histories. However, if physician services are required for other than psychiatric care during a psychiatric inpatient admission, the MHP would be responsible for covering the cost, provided the service has been prior authorized and is a covered benefit.)
- Maternal Infant Health Program (MIHP)
- Mental health services outside the MHP's contractual responsibility
- Outpatient partial hospitalization psychiatric care
- Personal care or home help services
- Private Duty Nursing services
- Services provided to persons with developmental disabilities and billed through the Community Mental Health Services Program (CMHSP)
- Services provided by a school district and billed through the Intermediate School District
- Substance abuse services through accredited providers, including:
 - Screening and assessment;
 - Detoxification;
 - Intensive outpatient counseling and other outpatient services; and
 - Methadone treatment

- Transportation for services not covered by the MHP.

1.3 SERVICES THAT MHPS ARE PROHIBITED FROM COVERING

- Elective therapeutic abortions and related services. Abortions and related services are covered when medically necessary to save the life of the mother or if the pregnancy is a result of rape or incest;
- Experimental/Investigational drugs, procedures or equipment;
- Elective cosmetic surgery; and
- Services for treatment of infertility.

*MPM, October 1, 2013 version
Medicaid Health Plan Chapter, page 1
(Underline added by ALJ)*

In addition to the above policy, the MHP indicated that the plan uses the national Surgical Treatment for Gynecomastia criteria (breast reduction surgery for males) in making decisions for requests for this surgery. This criteria is quite lengthy. The specific clinical criterion contains 8 criteria, ALL of which must be met in order for the procedure to be approved. These include, excess breast tissue that is glandular and not fatty; either a Grade II, III, or IV; other causes of gynecomastia have been ruled out including reversible drug treatments (when drugs can be discontinued); no evidence of having used illicit drugs; if caused by obesity (BMI >30) must be documented that patient failed to respond to clinically supervised, comprehensive weight loss and exercise program for at least 6 months; symptoms are significant (including pain) and not resolved by more conservative treatment for at least 6 months; and hormonal causes have been excluded by appropriate laboratory testing. See Respondent Attachment D, pages 1-3.

As to the weight loss criteria, this ALJ does not find that Appellant failed to follow this guideline. Evidence shows that Appellant has lost 65 pounds. However, Appellant's BMI is still >30. However, the weight loss issue is not the only ground on which the MHP criteria allows it to deny Appellant's request. There are a number of other reasons.

Appellant bears the burden of proving by a preponderance of the evidence that the MHP erred. Moreover, in reviewing the MHP's decision, this Administrative Law Judge's jurisdiction is limited to the information available at the time the decision was made.

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Here, given the information submitted along with the prior authorization request for surgery, the MHP properly denied Appellant's request. That documentation does not contain evidence that Appellant met all of the criteria identified in Attachment D. The MHP may deny absent the required documentation. And, this ALJ must uphold that denial when the evidence supports the decision. Thus, the denial is upheld.

It is noted however, that Appellant may be eligible if he can establish that he meets the criteria established in the MHPs' guidelines and reapplies. As the case stands, at the time of the denial and evidence in existence at that time, the denial must be upheld.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.

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

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK [REDACTED]

cc: [REDACTED]

***** 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.