

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

██████████,

Appellant

Docket No. 2014-35444 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.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. ██████████ appeared on her own behalf and provided testimony. ██████████, Appeals Coordinator, represented the Respondent, ██████████ (MHP). Dr. ██████████, MD, Medical Director, appeared as a witness for the MHP.

ISSUE

Did the Department properly deny the Appellant's prior authorization request for a labiaplasty?

FINDINGS OF FACT

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

1. The Appellant is an ██████ year old Medicaid beneficiary, born ██████████, who suffers from labial hypertrophy. (Exhibit B)
2. On ██████████, Dr. ██████████ D.O., submitted a prior authorization request on behalf of the Appellant for a labiaplasty. The request was accompanied by office notes that described the internal notes. (Exhibit A, p. 1; Exhibit B; Testimony)
3. On ██████████, the MHP sent the Appellant and Dr. Gillum notices indicating the prior authorization request was denied. The notice indicated the procedures were denied due to the request being cosmetic in nature and therefore it wasn't a covered service. (Exhibit A, p. 1; Exhibit B; Testimony)

4. On ██████████, the Michigan Administrative Hearings System (MAHS) received from the Appellant a request for hearing.
5. The notes provided to the MHP did not include external examination notes and did not provide reasons as to why the surgery was medically necessary. (Testimony)

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 Michigan Department of Community Health 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 Medicaid Health Plans.

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 coverage's 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:

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2013, pp. 22, 23.

The Medicaid Provider Manual provides, in pertinent part, as follows:

1.9 PRIOR AUTHORIZATION

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. It does not serve as an authorization of fees or beneficiary eligibility. Different types of services requiring PA include:

- Procedures identified as requiring PA on the procedure code databases on the MDCH website;
- Procedures/items that are normally noncovered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery, off-label use drugs, etc.); and
- Referrals for elective services by out-of-state nonenrolled providers.

*Medicaid Provider Manual
Practitioner Chapter
April 1, 2014 page 4*

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.

*Medicaid Provider Manual
Providers Section
April 1, 2014, pp 18, 19.*

SECTION 12 – SURGERY – GENERAL

Medicaid covers medically necessary surgical procedures.

*Medicaid Provider Manual
Practitioner Chapter
April 1, 2014, p 60.*

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.

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

Dr. ████████ testified that Appellant's prior authorization request was denied as the documentation provided with the request did not show that the surgery was medically necessary as it was missing both the reasons for the surgery as well as the notes detailing an external examination.

After review of the record and review of the applicable policy, I have concluded the MHP was correct in their decision to deny the Appellant's prior authorization request. I do not find this surgery as identified generally, meets the requirements for approval under the Medicaid Provider Manual.

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Based on the evidence and documentation submitted, Appellant did not prove, by a preponderance of evidence, that the surgery requested was of medical necessity.

As much as this administrative law judge might sympathize with Appellant, he cannot ignore the clear policy found in the Medicaid Provider Manual. Accordingly, the Department's 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 Department properly denied the Appellant's request.

IT IS THEREFORE ORDERED that:

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

Corey A. Arendt
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

CAA/

cc:

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.