

**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. 2014-4219 QHP

Case No. ██████████

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. ██████████, Director, Member Services, represented ██████████, the Medicaid Health Plan (hereinafter MHP). Dr. ██████████, 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, ██████████ Health Plan of Michigan. (Exhibit A, p 8)
2. On or about ██████████, the MHP received a request for breast-reduction surgery from Appellant's physician. Appellant's physician noted that Appellant was complaining of pain, poor posture, difficulty with clothes, difficulty exercising, intertrigo and shoulder grooving. Appellant's physician noted that Appellant's pain is located in the back, neck, shoulders and lower back and is moderate to severe. (Exhibit A, pp 8-27)
3. On ██████████, the MHP sent Appellant a denial notice, stating that the request for breast-reduction surgery was not authorized under the ██████████ Health Plan of Michigan Utilization Guidelines because the notes

submitted did not show that Appellant's conditions had not responded to appropriate conservative (non-surgical) treatment. (Exhibit A, pp 28-34)

4. On ██████████, the MHP received additional documentation from Appellant's physician for a Level I review. (Exhibit A, pp 35-41)
5. Appellant's medical documentation was sent to an independent review organization (IRO), the Medical Review Institute of America, for review. The IRO also concluded that Appellant's request for breast reduction surgery was properly denied. (Exhibit A, pp 42-48)
6. On ██████████, the MHP sent Appellant a denial notice indicating that her request for breast reduction surgery was denied because the documentation submitted did not show at least a three month trial of physical therapy to strengthen Appellant's back and stomach muscles (core body conditioning) to help relieve pain. Additionally the documentation did not show at least a three month trial and failure of other non-surgical treatments, such as wearing a well fitted support bra, or taking non-steroidal anti-inflammatory medications or muscle relaxants. (Exhibit A, pp 49-54)
7. Appellant requested a formal, administrative hearing contesting the denial was received by the Michigan Administrative Hearing System on ██████████.

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.
- 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, Reduction Mammoplasty section, when reviewing Appellant’s prior authorization request, which provides that Reduction Mammoplasty is covered if all of the following criteria are met:

- A. The medical record must show documentation of at least 2 of the following criteria, present for at least 6 months and which have not responded adequately to appropriate conservative, non-surgical interventions (including but not

limited to):

- i. Back, neck or shoulder pain of long standing duration (6 months) that has been evaluated and determined not to be related to other diagnosis such as scoliosis, arthritis or of a mechanical nature, and that has not responded to at least three consecutive months of conservative measures including, but not limited to, all of the following:
 - a) Appropriate support bra (e.g. sports type with wide straps
 - b) Exercises
 - c) Heat/cold treatments
 - d) Non steroidal anti-inflammatory agents (NSAID's) and/or
 - e) Muscle relaxants
- ii. Ulceration of the skin of the shoulder or significant and longstanding shoulder grooving not responding to conservative treatment over a 12-month period.
- iii. Chronic intertrigo, eczema, dermatitis, and/or ulceration in the infra-mammary fold between the pendulous breasts and the chest wall, not responsive to at least six months of dermatologic treatments (e.g. antibiotics and/or antifungal therapy) and conservative measures (e.g. good skin hygiene). By themselves, these dermatologic problems are not considered medically necessary indications for reduction mammoplasty.

(Exhibit A, pp 55-58)

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 at least a three month trial of physical therapy to strengthen Appellant's back and stomach muscles (core body conditioning) to help relieve pain. Additionally the documentation did not show at least a three month trial and failure of other non-surgical treatments, such as wearing a well fitted support bra, or taking non-steroidal anti-inflammatory medications or muscle relaxants.

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Appellant testified that she has chronic pain in her back and neck and her posture is hunched forward due to her large breast size. Appellant indicated that her breasts weigh the same as an infant. Appellant testified that she is now working with her doctor to get into physical therapy.

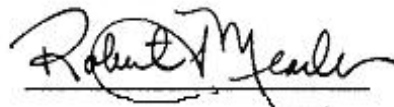
The documentation provided with the prior authorization request does not establish that Appellant has met the criteria for prior approval of breast-reduction surgery. Medical necessity of the requested procedure was not established based on the information available to the MHP when it reviewed Appellant's prior authorization request. Accordingly, the MHP's denial was proper based on the information available at that time. Appellant can re-submit for prior approval at any time with additional supporting documentation.

DECISION AND ORDER

The ALJ, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Appellant's request for breast-reduction surgery based on the available information.

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.



Robert J. Meade
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[REDACTED]
cc: [REDACTED]

Date Signed: November 26, 2013

Date Mailed: November 26, 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 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.