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. 15-002138 MHP

[redacted]

Appellant.
_____/

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 a request for a hearing filed on behalf of the minor Appellant.

After due notice, a hearing was held on [redacted], Appellant's mother, appeared and testified on Appellant's behalf. [redacted], paralegal, represented [redacted], the Respondent Medicaid Health Plan ("MHP"). [redacted], Medical Director, testified as a witness for Respondent.

This case is duplicative of Docket # 2014-34277, signed by Administrative Law Judge [redacted] on [redacted] That decision is herein incorporated in its entirety.

ISSUE

Did the MHP properly deny Appellant's request for laser surgery to remove a lesion on her cheek?

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 [redacted] year-old female beneficiary, date of birth [redacted] who has been enrolled in the Respondent MHP off and on since [redacted]. (Respondent's Exhibit A, page 1).

2. On or about [redacted], the MHP received a prior authorization request submitted on behalf of Appellant from [redacted] for laser surgery to remove a lesion on Appellant's cheek.

3. In the request form, [redacted] indicated that Appellant had been diagnosed with left face pigmented nevus.

4. Progress notes regarding a [redacted] consultation with a [redacted] were also attached to the prior authorization request.

5. In those notes, [redacted] wrote that Appellant presented for evaluation of pigmented nevus at the left cheek and nose and that the nevus has grown darker and larger over time.

6. [redacted] also wrote that several noninvasive treatments had been tried without success and that several options, including laser surgery to remove the nevus were discussed.

7. However, [redacted] did not identify any medical risks associated with the nevus or what medical problem surgery would be addressing.

8. Appellant also did not report any sensation, ulceration or discomfort from the nevus.

9. On [redacted], the MHP sent Appellant's parents written notice that the prior authorization request for surgery was denied.

10. Specifically, the denial notice stated:

> You asked for surgery to remove a growth on your child's cheek. Your child's doctor sent us information. We looked at the notes. They did not show that your child's health was in jeopardy. They did not show this interfered with your child's daily function. We did not see the medical problem that was going to be fixed. This makes this a cosmetic issue rather than a medical. The issue does not appear to affect your child's physical health. Cosmetic procedures are not part of your child's health care coverage. We cannot approve your child's request at this time.

Respondent's Exhibit A, page 3

11. On [redacted], the Michigan Administrative Hearing System (MAHS) received the request for hearing filed on Appellant's behalf in this matter.

12. On [redacted], a hearing was held by Administrative Law Judge (ALJ) [redacted].

13. On [redacted] Affirmed the Department's actions stating that the MHP properly denied the Appellant's request for laser surgery.

14. On [redacted] a review was conducted by the MHP [redacted], under direction of [redacted], Medical Director, and determined that The type of procedure requested for Appellant's condition to remove an abnormal skin growth from Appellant's face is considered to be experimental not proven to help this type of problem. The health plan does not approve experimental treatments. The request cannot be approved at this time. (Respondent's Exhibit A page 3)

15. On [redacted], the MHP sent Appellant notice of the denial.

16. On [redacted], the department received a request for a hearig to contest the negative action.

CONCLUSIONS OF LAW

Regulations governing the hearing and appeal process for applicants and recipients of public assistance in Michigan are found in Mich Admin Code, R 400.901 through R 400.951. Rule 400.903(1) provides as follows:

> An opportunity for a hearing shall be granted to an applicant who requests a hearing because [a] claim for assistance is denied or is not acted upon with reasonable promptness, and to any recipient who is aggrieved by a Department action resulting in suspension, reduction, discontinuance, or termination of assistance.

A request for hearing must be in writing and signed by the claimant, petitioner, or authorized representative. Mich Admin Code, R 400.904(1). Moreover, the Department of Human Services Bridges Administrative Manual (BAM) 600 provides in relevant part as follows:

> The client or authorized hearing representative has *90 calendar days from the date of the written notice of case action to request a hearing*. The request must be received anywhere in DHS within the 90 days. [Emphasis added.]

The Department's Notice of Case Action to Claimant was dated [redacted].However, Claimant did not file a request for hearing to contest the Department's action until [redacted].

Appellant's hearing request was not timely filed within ninety days of the Notice of Case Action and is, therefore, **DISMISSED** for lack of jurisdiction.

In the alternative, even if this ALJ would have ben able to retain jurisdiction of this matter:

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, 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.
>
> *MPM, January 1, 2014 version*
> *Medicaid Health Plan Chapter, page 1*
> *(Emphasis added by ALJ)*

As stated in the above policy, a MHP, "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." Here, the pertinent sections of the MPM state:

> **SECTION 12 – SURGERY – GENERAL**
>
> Medicaid covers medically necessary surgical procedures.
>
> * * *
>
> **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.
>
> *MPM, January 1, 2014 version*
> *Practitioner Chapter, pages 60, 66*

As stated in the above policy, "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 MHP has developed its own prior authorization requirements regarding Cosmetic and Reconstructive Procedures (Respondent's Exhibit A, pages 10-11) and, in the pertinent parts, that criteria limits cosmetic surgeries in a similar manner to the MPM:

> **Indications for Coverage**
>
> Some states require benefit coverage for services that UnitedHealthcare considers cosmetic procedures, such as repair of external congenital anomalies in the absence of a functional impairment. Please refer to enrollee's plan specific documents.
>
> I. **Required Documentation:**
>
> **The decision regarding whether the requested procedure will be covered as a reconstructive or excluded from coverage as cosmetic will require review of the following clinical information/documentation, and such other documentation as may be reasonably requested:**
>
> A. Contemporaneous physician office notes with the history of the medical condition(s) requiring treatment or surgical intervention. This documentation must include **ALL of the following:**
>
> i. A well-defined physical and/or physiological abnormality resulting in a medical condition that has required or requires treatment; AND
>
> ii. The physical and/or physiological abnormality has resulted in a functional deficit; AND
>
> iii. The functional deficit is recurrent or persistent in nature
>
> B. Appropriate clinical studies/tests addressing the physical and/or physiological abnormality that confirm its presence and the degree to which it is causing impairment
>
> C. High-quality color photographs, where applicable, documenting the physical and/or physiological abnormality accounting for the

functional impairment (as defined in the Definition section below). The date taken and the service reference identification number (obtained at time of notification) or patient's name and ID number must be documented on the photograph(s).

D. Treating physician's plan of care (proposed procedures), which must include the expected outcome for the improvement of the functional deficit.

II.**Criteria for a Coverage Determination as Reconstructive:**

When complete, we will review the information supplied above to render a coverage determination. A requested procedure will be deemed reconstructive and therefore covered when:

A. There has been documentation of a physical and/or physiological abnormality and quantification by contemporaneous office notes, objective studies and tests, and photographs, where applicable, of the physical and/or physiological abnormality

B. There is documentation that the physical abnormality and/or physiological abnormality is causing a functional impairment (as defined in the Definition section below) that requires correction

C. The proposed treatment is of proven efficacy; and is deemed likely to significantly improve or restore the patient's physiological function

* * *

Coverage Limitations and Exclusions

Some states require benefit coverage for services that UnitedHealthcare considers cosmetic procedures, such as repair of external congenital anomalies in the absence of a functional impairment. Please refer to enrollee's plan specific documents.

1. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without

> improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.
>
> 2. Any procedure that does not meet the reconstructive criteria above in the Indications for Coverage section

Respondent's Exhibit A, pages 11-12

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.

In this case, the MHP determined that the documentation submitted for the prior authorization request did not meet the above criteria found in its guidelines or in the MPM. Specifically, the documentation submitted did not identify any medical reason for the surgery or describe any health risks posed by the nevus. Instead, based on the prior authorization request and attached progress notes, the requested surgery appears to be strictly for non-covered reasons.

Appellant's representative agrees that the request and attached documentation does not reflect any medical need for the procedure, but she argues that such a medical need does exist. According to Appellant's representative, the nevus is still growing and poses a danger to Appellant's eye. Appellant is also self conscious about the growth.

However, as acknowledged by Appellant's representative, the submitted documentation fails to document any need for the surgery and the 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. The procedure is currently considered to be cosmetic and is thus, not a covered service. 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 Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Appellant's request for laser surgery to remove a lesion on her cheek. The Medicaid Health plan's decision would have been affirmed.

[redacted]
Docket No15-002138 MHP
Decision and Order

IT IS THEREFORE ORDERED that:

The request for a hearing is **DISMISSED** as untimely.

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

LYL/db

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.