STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-005970 MHP
Case No. [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.*, following the Appellant's request for a hearing.

After due notice, a telephone hearing was held on [redacted]. Appellant appeared and testified. Appellant's friend [redacted] appeared and testified on her behalf and helped with translation from English to Arabic when Appellant had trouble understanding. [redacted], Inquiry Dispute Appeal Resolution Coordinator; and [redacted], Medical director, appeared and testified on behalf of [redacted] of Michigan. (MHP or [redacted] or Respondent)

Respondent's Exhibit A pages 1-54 were admitted as evidence.

ISSUE

Did the MHP properly deny the Appellant's request 19318 REDUCTION OF LARGE BREAST – reduction Mammoplasty?

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. [redacted] Healthcare of Michigan ("MHP") is contracted with the state of Michigan to arrange for the delivery of health services to Medicaid recipients.

2. At all times relevant to this case, Appellant was enrolled in the MHP.

3. On [redacted], [redacted] Healthcare received a Prior Authorization request from Appellant's physician, requesting 191318 REDUCTION OF LARGE BREAST – Reduction Mammoplasty.

4. On [redacted], [redacted] sent Appellant a Notice of denial stating: The [redacted] Utilization guidelines for

> Reduction Mammoplasty requires documentation including an evaluation from another medical doctor (example, Primary Care Provider, Family Practice, Internal Medicine, General Surgeon, Physiatrist, Plastic Surgeon) other than the one performing (going to do) the surgery, who has determined (believes) there is a reasonable likelihood the member's symptoms are primarily (mostly) due to macromastia (very large breasts) and that reduction mammoplasty (breast reduction) is likely to result in improvement of chronic pain. (Respondent's Exhibit A page 5)

5. On [redacted], Appellant filed a Request for Hearing with the Michigan Administrative Hearing System (MAHS) to contest the negative action.

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 MHPs.

The Respondent is one of those MHPs.

> 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 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 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:
>
> - Ambulance and other emergency medical transportation
> - Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
> - Certified nurse midwife services

- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support
- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21 [Article 1.020

Scope of [Services], at §1.022 E (1) contract, 2010, p. 22].

(1) The major components of the Contractor's utilization management (UM) program 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.
(e) The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review. [Contract, *Supra,* p. 49].

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."

[redacted] determined:

The [redacted] of Michigan Utilization Guidelines for Reduction Mammoplasty requires documentation including an evaluation from another medical doctor (example, Primary Care Provider, Family Practice, Internal Medicine, General Surgeon, Physiatrist, Plastic Surgeon) other than the one performing (going to do) the surgery, who has determined (believes) there is a reasonable likelihood the member's symptoms are primarily (mostly) due to macromastia (very large breasts) and that reduction mammoplasty (breast reduction) is likely to result in improvement of chronic pain. (Respondent's Exhibit A page 5)

The Molina Medical Director also testified that in addition to the second opinion from a qualified medical doctor supporting the Plastic surgeon's decision to perform breast reduction surgery, that Appellant's primary care physician also failed to provide the MHP with Appellant's height and weight, which are required to calculate body surface to ensure that 482 grams is the proper amount of breast tissue to be removed. Once that information has been provided, [redacted] can make an updated assessment as to whether Appellant meets the criteria for Breast Reduction coverage.

Appellant testified that she has back and neck pain. The medical documentation indicates that Appellant has grooves in the shoulders from bra straps, and failed therapy and medications. Respondent's Exhibit A page 3.

Appellant has failed to satisfy the burden of proving by a preponderance of the evidence that the MHP improperly denied the requested service. The denial is based upon the fact that Appellant failed to provide the required information that the MHP needs to make a possible favorable determination. The decision to deny the request for authorization must be upheld under the circumstances. The Appellant may have her doctor re-submit medical information which includes her height, and weight, as well as a second opinion by a qualified medical doctor to Molina Healthcare for an another consideration for approval for 191318 REDUCTION OF LARGE BREAST – Reduction Mammoplasty.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP's denial of the Appellant's request for 191318 REDUCTION OF LARGE BREAST – Reduction Mammoplasty.

IT IS THEREFORE ORDERED that:

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

Landis Y. Lain
Administrative Law Judge
for Nick Lyion, Director
Michigan Department Health And Human Services

LYL/[redacted]

[redacted]
Docket No. 15-005970-MHP
Decision and Order

cc: [redacted]

Date Signed: [redacted]

Date Mailed: [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.