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. 15-010169-MHP
Case No. [redacted]

Appellant
_____/

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 [redacted]. Appellant appeared on her own behalf. Appellant was represented at the hearing by her father, Attorney [redacted]), Appeals Coordinator, represented [redacted] (hereinafter MHP).

Appellant's Exhibits 1-2 (photographs of Appellant) and Respondent's Exhibit A pages 1-38 were admitted as marked as evidence without objection.

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 [redacted]-year-old female (date of birth: [redacted]) Medicaid beneficiary who is currently enrolled in the Respondent MHP, [redacted] of Michigan.

2. On or about [redacted], the MHP received a request for breast-reduction surgery from Appellant's physician. Appellant's physician noted that Appellant has increasing symptoms due to the size of her breasts which include back pain, shoulder pain, neck pain and intertriginous rashes. The pain is not relieved with non-narcotic analgesics. The patient has a problem with exercise and normal activity due to weight and size of the breast. Exam shows large, pendulous breasts with sternal notch to

nipple distance of 32 cm. Her bra size is 38DD and her weight is 160lbs. This surgery would be done to relieve the patient's symptoms and to improve her ability to participate in normal daily activities. Approximately 500 grams will be removed from each breast. (Respondent's Exhibit A page 1)

3. On [redacted], the MHP sent Appellant a denial notice, stating that the request for breast-reduction surgery was not authorized under the [redacted] Utilization Guidelines because the provided documentation does not show severe shoulder grooving or a rash that has been unresponsive to prescription medication.

4. On [redacted], the Michigan Administrative Hearings System received Appellant's Appeals request for a hearing contesting the MHP's denial of breast reduction surgery.

5. On [redacted], the MHP received the request for a hearing.

6. On [redacted], the MHP received Notice of Hearing.

7. On [redacted], the MHP sent information included in the original request and information provided with the appeal request to Advanced Medical Reviews for a specialty advisor review. AMR reviewed the request and indicated that the request for bilateral reduction mammoplasty was not medically necessary. The review issued by AMR indicates that there is no documented failure of at least a continuous three month trial of appropriate medical management. Photos do not show shoulder grooving or intertrigo. (Respondent's Attachment F)

8. On [redacted], the MHP Appeals Committee reviewed the request with member participating by phone. The denial was upheld. The member's determination letter indicates the denial was upheld due to the fact that submitted documentation does not show a rash that has been unresponsive to prescription medication. The provided photos do not demonstrate severe shoulder grooving and the documentation provided from [redacted] did show good response to physical therapy with steady gains in pain control and tolerance for activity. (Respondent's Exhibit G)

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 Medical Review Criteria Guidelines for Managing Care – Breast Procedures: Augmentation or Reduction Mammaplasty; Post-Mastectomy Prostheses, 14th Edition, 2015 which indicates that:

> The following indications (all must apply) will be required to determine medical necessity for this procedure prior to authorization:
>
> A. Excessively large pendulous natural (no implants) breasts out of proportion to the rest of the individual's normal or usual body habitus, and;
> B. Pain involving the upper back and/or shoulder regions 9thoracic or cervical), severe; chronic (at least 6 months duration) that is inadequately responsive to conservative therapy (appropriate breast support, weight loss if necessary) for one year or longer; and/or painful kyphosis documented by x-ray is present, and/or thoracic nerve root compression with ulnar distribution pain is demonstrable, and
> C. Should bra strap discomfort (using appropriate bra support and wide bra straps) with demonstrable severe shoulder grooves due to bra strap pressure and/or intractable intertrigo unresponsive to appropriate topical therapy demonstrated on a frontal and lateral photo placed in a sealed envelope with the authorization request and following review; returned to the requesting physician to be maintained as a part of the permanent record; and
> D. Three or more years since the start of regular menses or 18 years or older. (Respondent's Exhibit A page 1)

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(DHHS)-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. Documentation did indicate that "Patient has achieved significant gains with rehabilitation. Continues to have good response with less guarding and more relaxed posture. The photos did not indicate severe shoulder

grooves due to bra strap pressure and/or intractable intertrigo unresponsive to appropriate topical therapy." The [redacted] Representative also stated that Appellant had not established that her back issues were as a result of her large breasts rather than the previous back injury alleged by Appellant.

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 testified that she was in the service and in [redacted] injured her back. She was discharged from the service because of her back problems. 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.

Landis Y Lain
Administrative Law Judge
for Nick yon, Director
Michigan Department of Health and Human Services

LYL[redacted]

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 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.