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. 15-013904 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 clinical therapist, Cother Abdo and her plastic surgeon, [redacted], appeared and testified on her behalf and helped with translation from English to Arabic when Appellant had trouble understanding.

[redacted], paralegal; and [redacted], Medical Director, appeared and testified on behalf of Respondent, [redacted]. (Respondent or MHP)

Respondent's Exhibit A pages 1-29 were admitted as evidence.

ISSUE

Did the MHP properly deny the Appellant's request for breast reconstructive surgery?

FINDINGS OF FACT

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

1. [redacted] ("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], Respondent received a prior authorization request for Breast Reconstructive Surgery for Appellant.

4. On [redacted], Respondent denied Appellant's request for breast reconstruction surgery stating: "You asked for surgery. You had burns to your chest. You have had reconstruction of your breasts. You want additional breast surgery. We looked at our health plan rules. We looked at the information sent to us. We do not see what functional problems are caused by the breast problems. We do not see that our health plan rules were met. We cannot approve your request at this time, based on the information we had to review." Respondent's Exhibit #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] Cosmetic and Reconstructive Procedures states that the following criteria must be met for a procedure to be considered reconstructive and medically necessary:

1. There is documentation that the physical abnormality and/or physiological abnormality is causing a functional impairment that requires correction.

2. The proposed treatment is of proven efficacy; and is

> deemed likely to significantly improve or restore the patient's physiological function.

Medically Necessary means Covered Services provided by the provider which are required to identify, treat or avoid illness or injury to a Member which are (i) consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury; (ii) appropriate with regard to standards of medical practice; (iii) not primarily for the convenience of the Member, or the Member's attending or treating physician, or another health care provider; (iv) and the most appropriate supply or level of service which can be safely provided to the Member. Not all Medically Necessary services are Covered Services under this Certificate. (Respondent's Exhibit A page 29)

Functional/Physical Impairment is defined in Procedure:

A physical/functional or physiological impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions. (Respondent's Exhibit A page 8)

Reconstructive Procedures is defined as:

When the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. Respondent's Exhibit A page 8.

Respondent's representative testified that [redacted] Cosmetic and Reconstructive Procedures states explicitly that 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.

In this case, evidence indicates that Appellant was burned on her chest/breast when she was approximately eight years old. She has had several reconstructive surgeries in the past.

According to her physician, she has had several reconstructive surgeries in the past 25 years as she suffered third degree burns during the initial injury. Appellant's witness testified that this type of surgery is analogous to breast reconstruction after having a breast removed for breast cancer. The physical examination shows asymmetric breasts and breast deformities bilateral. She had no active hospital problems. The plan was for scar revision on the chest and fat grafting of the breasts. The procedure should be covered as it is not cosmetic.

Appellant testified that she has pain and burning in her chest and cannot sleep.

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. Appellant has not established the she has physiological dysfunction or functional impairment/limitation that would be relieved by breast reconstruction surgery. Appellant has provided insufficient medical documentation to establish that the current condition of her breasts causes a functional impairment or that proposed treatment is deemed likely to significantly improve or restore the patient's physiological function. Appellant has not established that the procedure is medically necessary. Appellant has not established that the procedure is for other than cosmetic purposes. The MHP's decision must be upheld.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the MHP appropriately denied Appellant's request for coverage of breast reconstruction surgery under the circumstances.

IT IS THEREFORE ORDERED that:

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

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

LYL/[redacted]

Date Signed: October 19, 2015

Date Mailed: October 20, 2015

[redacted]
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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 30 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.