RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

SHELLY EDGERTON
DIRECTOR

[redacted]

Date Mailed: May 16, 2016
MAHS Docket No.: 16-003583
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Landis Lain

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, upon the Petitioner's request for a hearing.

After due notice, a hearing was held on [redacted]. Petitioner [redacted] appeared on behalf of the Petitioner; [redacted], Appeals Coordinator, represented [redacted], the Medicaid Health Plan (MHP or Respondent).

Respondent's Exhibit A pages 1-30 were admitted as evidence.

ISSUE

Did the Medicaid Health Plan properly deny Petitioner's request for bilateral breast reduction?

FINDINGS OF FACT

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

1. McLaren Health Plan 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, Petitioner was enrolled in the MHP.

3. On [redacted], Respondent received a Prior Authorization request from Petitioner's physician, requesting bilateral breast reduction. (Attachment A)

4. On [redacted], the request was reviewed by the MHP Medical Director using [redacted] Managed Care criteria (Attachment B) and a denial was issued.

5. On [redacted], the MHP sent denial letters to Petitioner and a copy to Dr. [redacted] (Attachment C). The denial letter indicates that the provided documentation does not show chronic or acute rashes under the breasts, there is no documentation of severe shoulder grooving in the photos, and the breast size is not out of proportion with the member's body type.

6. On [redacted], Petitioner 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:

- Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
- A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
- Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
- An annual review and reporting of utilization review activities and outcomes/interventions from the review.
- 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."

Petitioner alleges that she is [redacted] tall and weighs [redacted] pounds. She wears a size [redacted] bra. She has back pain, shoulder pain and intertriginous rashes for five years due to large breasts.

Respondent alleges that the denial was issued using [redacted] Criteria (Attachment B). Page 3 of 8 (#3) of [redacted] Criteria state 'the following indications (all must apply) will be required to determine medical necessity for this procedure prior to authorization:

A. Excessively large pendulous natural breasts (no implants) 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 a painful kyphosis documented by x-ray is present, and/or thoracic nerve root compression with ulnar distribution pain is demonstrable, and
C. Shoulder bra strap discomfort (using appropriate bra support and wide 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, sealed envelope returned to the requesting physician to be maintained as a part of the permanent medical record; and
D. Three or more years since the start of regular menses or 18 years or older.

The provided documentation did not show intertrigo that has been unresponsive to appropriate topical therapy. The member's pharmacy profile, reviewed with the original request, did not indicate that the member had filled any powders, creams or ointments that would assist in the treatment of skin break-down and the submitted photos do not demonstrate shoulder grooving. In addition, the submitted photos do not show that the breasts are out of proportion with the member's body type.

[redacted], medical reports indicate no deformity or scoliosis in the musculoskeletal area. Petitioner had normal posture and gait. [redacted] bra size. (Respondent's Exhibit A pages 8-9)

This Administrative Law Judge determines that Petitioner 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 Petitioner 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. Petitioner has not established the she has physiological dysfunction or functional impairment/limitation that would be relieved by breast reconstruction surgery. The provided documentation did not show intertrigo that has been unresponsive to appropriate topical therapy. The member's pharmacy profile, reviewed with the original request, did not indicate that the member had filled any powders, creams or ointments that would assist in the treatment of skin break-down and the submitted photos do not demonstrate shoulder grooving. In addition, the submitted photos do not show that the breasts are out of proportion with the member's body type.

Petitioner 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. Petitioner has not established that the procedure is medically necessary. Petitioner 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 Petitioner's request for coverage of bilateral breast reduction surgery under the circumstances.

IT IS THEREFORE ORDERED that:

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

LL/[redacted]

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

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact

[redacted]

Petitioner

[redacted]

Community Health Rep

[redacted]