[redacted], MI [redacted]

Date Mailed: May 19, 2020
MOAHR Docket No.: 20-002216
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

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 May 13, 2020. Petitioner appeared on her own behalf. Holly Johnson, Appeals Coordinator, appeared on behalf of Priority Health, Respondent (Department).

Exhibits:

Petitioner	None
Department	A – Hearing Summary

ISSUE

Did the Department properly deny Petitioner's request for panniculectomy/abdominoplasty?

FINDINGS OF FACT

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

1. Petitioner is a Medicaid beneficiary, born [redacted]. (Exhibit A, p 13; Testimony)

2. On or about January 2, 2020, the Department received a Prior Authorization Request from Petitioner's provider for a panniculectomy/abdominoplasty. (Exhibit A, pp 11-25; Testimony)

3. On January 2, 2020, the Department advised Petitioner and her provider that the request was denied because the information supplied did not show the Petitioner as having a condition that interferes with her employment or a condition that causes significant disability or psychological trauma or was a

component of a program of reconstructive surgery for congenital deformity or trauma or contributed to a major health problem. (Exhibit A, pp 27-28; Testimony)

4. On March 4, 2020, following an Internal Appeal, the Department notified Petitioner that it was upholding the original denial. The notice indicated the supplied medical records did not show evidence that she met the coverage criteria outlined in the Medicaid Provider Manual. (Exhibit A, pp 7-10; Testimony)

5. On March 30, 2020, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing. (Exhibit A, pp 5-6)

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 Department 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.[1]

The Medicaid Provider Manual states, in relevant part:

1.3 SERVICES THAT MHPS ARE PROHIBITED FROM COVERING

- Elective therapeutic abortions and related services. Abortions and related services are covered when medically necessary to save the life of the mother or if the pregnancy is a result of rape or incest;
- Experimental/Investigational drugs, procedures or equipment;
- Elective cosmetic surgery; and
- Services for treatment of infertility.[2]

8.3 NONCOVERED SERVICES

The items or services listed below are not covered by the Medicaid program:

- Acupuncture
- Autopsy
- Biofeedback
- All services or supplies that are not medically necessary
- Experimental/investigational drugs, biological agents, procedures, devices or equipment
- Routine screening or testing, except as specified for EPSDT Program or by Medicaid policy
- Elective cosmetic surgery or procedures
- Charges for missed appointments
- Infertility services or procedures for males or females, including reversal of sterilizations

[1] Medicaid Provider Manual, Medicaid Health Plan Chapter, January 1, 2020, p 1.
[2] *Id* at p 3.

- Charges for time involved in completing necessary forms, claims, or reports

When the beneficiary needs a medical service recognized under State Law, but not covered by Medicaid, the service provider and the beneficiary must make their own payment arrangements for that noncovered service. The beneficiary must be informed, prior to rendering of service, that Medicaid does not cover the service. A Medicaid beneficiary in a nursing facility can use his patient-pay funds to purchase noncovered services subject to MDHHS verification of medical necessity and the provider's usual and customary charge. (Refer to the Nursing Facility Chapter for additional information.)[3]

With regard to Cosmetic Surgery, the MHP's policy provides, in relevant part:

The MPM addresses cosmetic surgery:

12.3 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.[4]

The Department's witness testified the requested surgery was not covered under the policy found in the Medicaid Provider Manual. The witness specifically indicated that the information submitted did not show that Petitioner met any of the above criteria for cosmetic surgery.

Petitioner did not refute the testimony provided by the Department. The Petitioner did mention that she is suffering psychologically but did not provide any documented evidence to substantiate her claims.

[3] Medicaid Provider Manual, General Information for Providers Chapter, January 1, 2020, pp 24-25.
[4] Medicaid Provider Manual, Practitioner Chapter, January 1, 2020, p 52.

Based on the evidence presented, Petitioner has failed to satisfy the burden of proving by a preponderance of the evidence that the Department improperly denied Petitioner's request. Therefore, the Department's denial must be affirmed.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, the Administrative Law Judge finds that the Department's denial of Petitioner's request was proper.

IT IS THEREFORE ORDERED that:

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

CA/sb

Corey Arendt
Administrative Law Judge
for Robert Gordon, 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 Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR 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. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

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

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

DHHS -Dept Contact

Managed Care Plan Division
CCC, 7th Floor
Lansing, MI
48919

Community Health Rep

Priority Health Choice
Kellie McCowan
1231E. Beltline NE
Grand Rapids, MI
49525-4501

Petitioner

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