GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
SUZANNE SONNEBORN
EXECUTIVE DIRECTOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

[redacted]
MI [redacted]

Date Mailed: February 9, 2024
MOAHR Docket No.: 23-009672
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.,* and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on January 31, 2024. Petitioner appeared on her own behalf. Leigha Klaver, Appeals Review Officer, appeared on behalf of the Respondent, the Michigan Department of Health and Human Services (Department). Dr. David Wartinger, a consultant physician, testified as a witness for the Department.

Exhibits:

Petitioner	None
Department	A – Hearing Summary

ISSUE

Did the Department properly deny Petitioner's prior authorization request for a left reduction mammoplasty?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Petitioner is an enrolled Medicaid beneficiary. (Exhibit A.)

2. In 2015, Petitioner underwent cancer treatment for her right breast involving a right breast lumpectomy and radiation treatment. (Exhibit A; Testimony.)

3. On October 3, 2023, the Department, received a prior authorization request completed on Petitioner's behalf, requesting a left breast reduction. (Exhibit A.)

4. On October 6, 2023, the Department sent Petitioner, a notification of denial. The notice stated the following:

> Based on the information reviewed, your request for left breast reduction has been denied by Medicaid. Elective cosmetic surgery or procedures are not covered by the Medicaid program. The left breast was not impacted by cancer therapy.[1]

5. On November 16, 2023, the Department, received a second prior authorization request completed on Petitioner's behalf, requesting a left breast reduction. (Exhibit A.)

6. On November 27, 2023, the Department sent Petitioner a second notification of denial. The notice stated the following:

> Based on the information reviewed, your request for breast reduction has been denied by Medicaid. Elective cosmetic surgery or procedures and all services or supplies that are not medically necessary are not covered by the Medicaid program. The left breast never received any cancer treatment, and the requested breast reduction is cosmetic in nature. No new or additional clinical information has been submitted since the previous denial. Medical documents from the previously submitted request was reviewed provide the beneficiary a comprehensive and fair review process.[2]

7. On December 28, 2023, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing. (Exhibit A.)

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 statutes, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program. Medicaid covered benefits are addressed for the practitioners and beneficiaries in the Medicaid Provider Manual (MPM) and, with respect to the delivery of services, the applicable version of the MPM states in part:

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[1] Exhibit A, p 9.
[2] Exhibit A, p 131.

SECTION 8 - DELIVERY OF SERVICES

8.1 FREE CHOICE

Beneficiaries are assured free choice in selecting an enrolled licensed/certified provider to render services unless they are patients in a state-owned and-operated psychiatric facility, enrolled in a Medicaid Health Plan (MHP), or otherwise specified.

8.2 RENDERING SERVICES

Enrollment in Medicaid does not legally require a provider to render services to every Medicaid beneficiary seeking care, except as noted below. Providers may accept Medicaid beneficiaries on a selective basis. However, a Medicare participating provider must accept assignment for Medicare and Medicaid dual eligibles.

Hospitals must provide emergency services as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42USC 1395dd.

If a Medicaid-only beneficiary is told and understands that a provider is not accepting them as a Medicaid patient and asks to be private pay, the provider may charge the patient for services rendered. The beneficiary must be advised prior to services being rendered that their **mihealth** card is not accepted and that they are responsible for payment.

All such services rendered must be in compliance with the provider enrollment agreement; contracts (when appropriate); Medicaid policies; and applicable county, state, and federal laws and regulations governing the delivery of health care services. (Refer to the Billing Beneficiaries Section of this chapter for more information.

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
- 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]

Moreover, regarding breast reconstruction surgery, the MPM further states:

12.2 BREAST RECONSTRUCTION SURGERY

Medicaid covers breast reconstruction surgery following the diagnosis and treatment of breast cancer. Covered services include procedures related to the affected and the contralateral unaffected breast following a medically necessary mastectomy. The prior authorization requirements for these specified breast reconstruction procedure codes are waived when billed with appropriate ICD breast cancer

[3] MPM, General Information for Providers, July 1, 2023, pp 23-24.

> diagnosis codes. The specified CPT codes subject to this PA waiver are identified in the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)[4]

Here, as discussed above, Department denied Petitioner's request for a left breast mammoplasty after coming to the conclusion the request was an elective cosmetic surgery and, thus, not covered by the Medicaid Program.

Petitioner argued the denial of the request is in direct violation of "The Women's Health and Cancer Rights Act of 1998".

Policy is clear in that elective surgeries are not covered by Medicaid. Related to breast reconstruction, surgery policy does indicate Medicaid covers breast reconstruction surgery following the diagnosis and treatment of breast cancer. Covered services include procedures related to the affected AND the "contralateral unaffected breast" following a medically necessary mastectomy.

In this case, Petitioner had a prior "lumpectomy" which differs from a "mastectomy".[5]

Regarding what could be approved, Dr. Wartinger testified the Department might approve reconstructive surgery on Petitioner's right breast if there was a cosmetic defect following the lumpectomy. He further testified that the Department would have approved reconstruction of the left breast if a mastectomy had been performed, or reconstruction of both breasts if a bilateral mastectomy had been performed. However, he also testified that the request in this case includes purely cosmetic surgery on the breast that was not touched by cancer or treatment, and that it must therefore be denied given what was requested.

Given the record and applicable policy in this case, Petitioner has failed to meet her burden of proof; and the Department's decision must be affirmed.

As clearly provided by the above policies, elective cosmetic surgery or procedures are not covered by the Medicaid program. Accordingly, procedures to address a person's appearance, such as ptosis or asymmetry in breasts, no matter how understandably distressing, are not covered.

Moreover, to the extent Petitioner seeks the mastopexy as part of her treatment following the diagnosis of breast cancer, her request still must be denied. While the above policy provides for coverage of breast reconstructive surgery following the diagnosis and treatment of breast cancer; Petitioner seeks a mammoplasty of her left-unaffected breast. Department's witness credibly explained why such a procedure is considered cosmetic, as opposed to procedures that the Department might approve,

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[4] MPM, Practitioner, July 1, 2023, p 52.
[5] A "lumpectomy" is a partial mastectomy, and a "mastectomy" is the complete removal of the entire breast.

such as therapy on the right cancerous breast to restore contour or improve appearance following the diagnosis and treatment of breast cancer.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Department properly denied Petitioner's prior authorization request.

IT IS THEREFORE ORDERED that:

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

CA/pe

Corey Arendt
Administrative Law Judge
for Elizabeth Hertel, 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

Via Electronic Mail:

Agency Representative
Emily Piggott
DCH Appeals Section
222 N Washington Square
Lansing, MI 48909
Piggotte2@michigan.gov

DHHS Department Contact
Gretchen Backer
MDHHS
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P.O. Box 30479
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Via First Class Mail:

Petitioner
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