BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

ATLANTA CENTER FOR BREAST AND AESTHETIC SURGERY,	:	
Petitioner,	:	**Docket No.: 1737794**
	:	**1737794-OSAH-DCH-PROP-60-MALIHI**
v.	:	
	:	**Agency Reference No.: P15-0148**
DEPARTMENT OF COMMUNITY HEALTH,	:	
Respondent.	:	

INITIAL DECISION

I. INTRODUCTION

Petitioner Atlanta Center for Breast and Aesthetic Surgery (hereinafter "Petitioner") requested a hearing to dispute the decision of Respondent, the Department of Community Health (hereinafter "Department" or "DCH"), to deny prior authorization for a nipple/areola reconstruction procedure intended for a Medicaid-eligible patient. The hearing on this matter took place on July 20, 2017. Petitioner was represented at the hearing by Dr. Frederick Work, M.D. Ifuero Obaseki, Esq. represented Respondent.

On July 14, 2017, DCH filed an untimely motion to allow telephonic testimony of all of its witnesses at the July 20, 2017 hearing. Petitioner objected to DCH's motion. DCH's untimely motion therefore was denied pursuant to O.C.G.A. § 50-13-15(5), which requires that all parties consent to using telephonic communications at a hearing. In addition, DCH then moved to continue the hearing at the beginning of the hearing. Petitioner was available and ready to proceed. DCH's untimely and last minute motion to continue was also denied. After the hearing, DCH filed a "motion" to file addition documents in support of its position. This motion was imbedded in an email with no citation of authority—violating OSAH Rule 616-1-2-.1(1), (4). DCH's motion is denied.

For the reasons indicated below, DCH's action is **REVERSED**.

II. FINDINGS OF UNDISPUTED MATERIAL FACT

The following facts are undisputed:

1.

DCH is the state agency responsible for administering Georgia Medicaid, a cooperative state/federal program created through Title XIX of the Social Security Act. Through Medicaid, DCH compensates enrolled providers for covered services furnished to eligible members. DCH administers Medicaid pursuant to a State Plan approved by the Center for Medicare and Medicaid Services (CMS), the entity responsible for administering Medicaid at the federal level.

2.

Petitioner is an enrolled Medicaid provider. *See Exhibit R-B(1).*

3.

On or around September 9, 2015, Petitioner – through Dr. Frederick Work – evaluated patient L.H. to determine whether she was an appropriate candidate to undergo bilateral breast reduction surgery. L.H. reported suffering back pain and shoulder pain as a result of her large breasts. During the consultation, Dr. Work informed L.H. of the risks associated with bilateral breast reduction surgery, including loss of nipple sensation, the inability to breastfeed, and nipple necrosis. After being informed of such risks and Dr. Work's determination that she was an appropriate candidate, L.H. elected to proceed with the bilateral breast reduction surgery. *Testimony of Dr. Frederick Work; Exhibit R-B(1).*

4.

On or around October 6, 2015, Petitioner performed bilateral breast reduction surgery on L.H. At the time of surgery, Petitioner amputated L.H.'s nipples due to Petitioner's medical

determination L.H. had an increased risk of nipple areolar necrosis. This determination was made based on L.H. having long sternal notch to nipple distances and infra-mammary fold to nipple distances. *Testimony of Dr. Frederick Work; Exhibit R-B(2).*

5.

On or around November 20, 2015, L.H saw Petitioner for a six-week post-operation appointment. Petitioner determined bilateral nipple/areola reconstruction was the appropriate next step for L.H. *Testimony of Dr. Frederick Work; Exhibit R-B(2).*

6.

On or around December 3, 2015, Petitioner submitted a prior authorization request to DCH in order to perform a bilateral nipple/areola reconstruction and nipple tattooing for L.H. *Exhibit R-B(1).*

7.

On or around December 11, 2015, DCH denied Petitioner's request for bilateral nipple/areola reconstruction and nipple tattooing. DCH's peer reviewer for the prior authorization request stated that a bilateral nipple/areola reconstruction and nipple tattooing was: "[n]ot the standard of care in my opinion regardless of ethnicity. Lighter spots can be dermapigmented." DCH peer reviewers denied Petitioner's request again on March 15, 2016 and April 6, 2016. *Exhibit R-B(2); Exhibit R-B(1).*

8.

Petitioner appealed DCH's decision on the basis that bilateral nipple/areola reconstruction and nipple tattooing was the appropriate standard of care for L.H. and similarly situated patients. *Exhibit R-B(1).*

9.

DCH submitted Petitioner's appeal and supporting documentation to the Georgia Medical Care Foundation ("GMCF"), its peer review organization, for an Administrative Review. Based upon GMCF's review, DCH affirmed its original determination to deny Petitioner's request. DCH informed Petitioner of its determination in a letter dated April 7, 2017. That letter held: "[t]he standard of care at this time is to complete the procedure at the time of the reduction. Your point about the breast reduction being considered under the "Cancer Rights Act" as "partial mastectomy" does not make it valid that it would; therefore, be covered as a cancer procedure. However, this member shows no evidence of a diagnosis related to cancer." *Exhibit R-A.*

10.

DCH does not cover "cosmetic surgery or mammoplasties for aesthetic purposes." In Ambulatory Surgical Centers, which Petitioner qualifies as, services that are deemed not medically necessary will not be reimbursed by DCH. *Exhibit R-C.*

11.

Dr. Work testified DCH failed to consider the unique medical needs of different patient populations when reviewing Petitioner's prior authorization request for bilateral nipple/areola reconstruction and nipple tattooing. Specifically, unique medical risk factors associated with L.H.'s ethnicity, her very large breast size, the duration and complexity of the bilateral breast reduction surgery, and the possibility of asymmetrical breasts increased the risk of complications if a free nipple graft was performed contemporaneously with the bilateral breast reduction surgery. Dr. Work identified necrosis of the nipple, pain, a higher probability of infection, and a prolonged recovery period as complications associated with performing a free nipple graft in conjunction with a bilateral breast reduction surgery. *Testimony of Dr. Frederick Work.*

12.

Dr. Work testified on the benefits of performing bilateral nipple/areola reconstruction and nipple tattooing at a later date for L.H. and similarly situated patients after they have undergone bilateral breast reduction surgery. Identified benefits included nominal recovery time, the speed and outpatient nature of the procedure (it can be completed in thirty minutes), and the low rate of complications associated with performing bilateral nipple/areola reconstruction and nipple tattooing after a patient has undergone bilateral breast reduction surgery. *Testimony of Dr. Frederick Work.*

13.

DCH will reimburse Medicaid practitioners if bilateral nipple/areola reconstruction and nipple tattooing is performed in conjunction with a medically necessary bilateral breast reduction surgery. DCH will not reimburse Medicaid practitioners if the surgeries are performed 'staged' (e.g., the nipple/areola reconstruction and nipple tattooing is completed on a later date post-breast reduction surgery). *Testimony of Dr. Frederick Work.*

III. CONCLUSIONS OF LAW

1.

Because this matter involves an application for benefits, the burden of proof is on the Petitioner. Ga. Comp. R. & Regs. 616-1-2-.07(1)(e). The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.21(4).

2.

When a contested case is referred to the Office of State Administrative Hearings, the administrative law judge assigned to the case has "all the powers of the referring agency . . . ."

O.C.G.A. § 50-13-41(b). The evidentiary hearing is de novo, and the administrative law judge "shall make an independent determination on the basis of the competent evidence presented at the hearing." Ga. Comp. R. & Regs. 616-1-2-.21(1). To the extent an issue involves the interpretation of a federal statute; it is a question of law which is reviewed de novo. Draper v. Atlanta Indep. Sch. Sys., 518 F.3d 1275, 1284 (11th Cir. 2008).

3.

Medicaid is a joint federal-state program that provides comprehensive medical care for certain classes of eligible recipients whose income and resources are determined to be insufficient to meet the costs of necessary medical care and services. 42 U.S.C. §§ 1396 et seq.; Moore v. Reese, 637 F.3d 1220, 1232 (11th Cir. 2011). Participation is voluntary, "but once a state opts to participate it must comply with federal statutory and regulatory requirements." Id. All states have opted to participate and, thus, each must designate a single state agency to administer its Medicaid plan. Id.; 42 C.F.R. § 431.10(a), (b)(1). Georgia has designated DCH as the "single state agency for the administration" of Medicaid. O.C.G.A. § 49-2-11(f).

4.

The relationship between Medicaid providers and DCH is governed by the terms of DCH's manuals and the Statement of Participation that all providers are required to enter into as a prerequisite to enrollment. Both DCH and participating providers are contractually bound by the terms of the manuals. See Pruitt Corp. v. Ga. Dep't of Cmty. Health, 284 Ga. 158, 160 (2008); ABC Home Health Servs., Inc. v. Ga. Dep't of Med. Assistance, 211 Ga. App. 461, 463 (1993); State v. Stuckey Health Care, 189 Ga. App. 126, 129 (1989).

5.

DCH defines a procedure and/or service as medically necessary if the procedure and/or service is

> (a) appropriate and consistent with the diagnosis of the treating physician and the omission of which would adversely affect the eligible member's medical condition,
> (b) compatible with the standards of acceptable medical practice in the United States,
> (c) provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms,
> (d) not provided solely for the convenience of the member or the convenience of the health care provider or hospital,
> (e) not primarily custodial care unless custodial care is covered service or benefit under the member's evidence of coverage, and
> (f) there must be no other effective and more conservative or substantially less costly treatment, service and setting available.

Part I, Policies and Procedures for Medicaid/PeachCare for Kids, Definitions (hereinafter "Part I Manual").

6.

DCH requires Medicaid providers to obtain prior authorization or precertification from DCH for enumerated procedures. Part II, Policies and Procedures for Physician Services, Appendix E (hereinafter "Part II Manual"). Bilateral nipple/areola reconstruction and nipple tattooing are enumerated procedures that require approval from DCH prior to a Medicaid provider performing the procedure on an eligible patient. Id. In this matter, Petitioner believes bilateral nipple/areola reconstruction and nipple tattooing was medically necessary for L.H. and should have been approved by DCH. DCH disagrees with Petitioner's determination such procedures were medically necessary and denied Petitioner's request for prior authorization to perform the procedures.

7.

This is a case in which expert testimony would have been helpful in resolving the ultimate factual question whether bilateral nipple/areola reconstruction and nipple tattooing were medically necessary for L.H. Under 42 C.F.R. § 440.230(a), a state Medicaid plan must generally specify the amount, duration, and scope of each service it provides. However, the agency "may place appropriate limits on a service based on such criteria as medical necessity or on utilization controls procedures." 42 C.F.R. § 440.230(d). Further, federal regulations contain numerous provisions requiring State programs to have procedures for review of the "need for," "quality," and "timeliness," of Medicaid services or for determination that the services are "medically necessary." 42 C.F.R. §§ 456.22, 431.54(e), 431.54(f)(i), 438.210(a)(4), and 456.702. Based on all the limitations placed on Medicaid coverage of medical services, it is clear that the Medicaid program requires meaningful utilization review of proposed medical services to determine whether medical services are medically necessary.

8.

In order to determine whether a medical service is "medically necessary" under the definition provided in DCH's Part I Manual, it is necessary to rely on the opinions of members of the appropriate medical community. DCH had members of the appropriate medical community review Petitioner's prior authorization request to perform bilateral nipple/areola reconstruction and nipple tattooing for L.H. However, DCH failed to explain why the medical determination of their peer reviewers should be given more weight than the determination made by Petitioner, through Dr. Work.

9.

Since there is a dispute about whether the proposed procedures were medically necessary, and since neither party presented expert testimony to explain why their respective determination should be credited, it is necessary for the Court to look to the evidence and analyze the evidence in light of the standards and requirements discussed above.

10.

The evidentiary hearing before the Court is de novo, and the Court is obligated to "make an independent determination on the basis of the competent evidence presented at the hearing." Ga. Comp. R. & Regs. 616-1-2-.21(1). DCH's Part I Manual defines a procedure as "medically necessary" if it is consistent with the diagnosis of the treating physician, compatible with acceptable medical practices, provided in a safe, appropriate, and cost-effective setting, not provided solely for the convenience of the eligible member, and is the most cost-effective treatment available.

11.

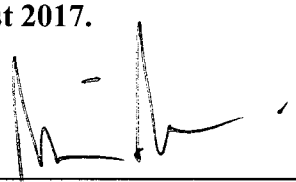
DCH presented limited evidence to the Court concerning why Petitioner's prior authorization request for bilateral nipple/areola reconstruction and nipple tattooing for L.H. was denied. DCH failed to offer the testimony of an expert in nipple/areola reconstruction. Therefore, the Court is limited to review the submitted evidence of the parties and the testimony of Dr. Work. Ultimately, the Court finds Dr. Work's testimony to be more persuasive than DCH's evidence concerning whether the discussed procedures were medically necessary for the following reasons: (1) bilateral nipple/areola reconstruction and nipple tattooing was consistent with the diagnosis of L.H.'s treating physician; (2) bilateral nipple/areola reconstruction and nipple tattooing was consistent with compatible medical practices for patients similarly situated

to L.H., who have higher risks of skin depigmentation if a free nipple graft is performed in conjunction with a bilateral breast reduction; (3) the proposed procedure would not be solely for the convenience of the eligible member; and (4) the proposed procedure would be provided in a cost-effective manner relative to a free nipple graft, where L.H. and similarly situated patients face higher rates of complications when such procedure is performed in conjunction with a bilateral breast reduction. Based on these factors, the Court concludes Petitioner's proposed procedures for L.H. are medically necessary.

IV. DECISION

In accordance with the foregoing Findings of Fact and Conclusions of Law, DCH's action denying the Petitioner's request for Prior Authorization for a bilateral nipple/areola reconstruction and nipple tattooing for a Medicaid-eligible member is hereby **REVERSED**.

SO ORDERED, this day of 25 **August 2017.**



Michael Malihi, Judge