STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-16101 QHP
Case No. [redacted]

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 Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] (Appellant) appeared and testified on her own behalf. [redacted], testified as a witness for the MHP.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for Bariatric surgery?

FINDINGS OF FACT

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

1. Appellant is a Medicaid beneficiary who was enrolled in [redacted]) at all times relevant to this matter.

2. On or about [redacted], the MHP received a request from Appellant's medical doctor, requesting that Appellant be approved for Gastric Bypass surgery. (Exhibit 1, p. 1)

3. According to the prior authorization request, Appellant was 5'4", 332.5 lbs, with a body mass index (BMI) of 57; and Appellant was diagnosed with diabetes mellitus, gastoesophageal reflux, fatty liver disease, urinary incontinence, chronic back pain, arthritis, difficulty walking, depression, and asthma. (Exhibit 1, p. 1)

4. On [redacted], the MHP sent Appellant a letter, stating that the request for Bariatric surgery was denied because there was no evidence that she had been in a medically supervised weight loss program for a minimum of one year. (Exhibit 2)

5. On [redacted], the State Office of Administrative Hearings and Rules received Appellant's request for Administrative Hearing, protesting the denial.

6. Appellant joined the Medical Weight Loss Clinic on [redacted]. (Exhibit 4)

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 Medicaid Health Plans.

The Respondent is one of those Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors 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 1-Z.

Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, September 30, 2004.

> The major components of the Contractor's utilization management plan 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 Contractor must establish and use a written prior approval policy and procedure for utilization management 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 utilization management decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Article II-P, Utilization Management, Contract, September 30, 2004.

The MHP representative testified that its Bariatric surgery policy is consistent with Medicaid policy. Medicaid policy covers treatment of obesity if it is posing life-threatening co-morbidities **and other conservative methods of weight control have been tried and failed**. The Medicaid policy is as follows:

4.22 WEIGHT REDUCTION

Medicaid covers treatment of obesity when done for the purpose of controlling life-endangering complications, such as hypertension and diabetes. If conservative measures to control weight and manage the complications have failed, other weight reduction efforts may be approved. The physician must obtain PA for this service. Medicaid does not cover treatment specifically for obesity or weight reduction and maintenance alone.

The request for PA must include the medical history, past and current treatment and results, complications encountered, all weight control methods that have been tried and have failed, and expected benefits or prognosis for the method being requested. If surgical intervention is desired, a psychiatric evaluation of the beneficiary's willingness/ability to alter his lifestyle following surgical intervention must be included.

If the request is approved, the physician receives an authorization letter for the service. A copy of the letter must be supplied to any other provider, such as a hospital, that is involved in providing care to the beneficiary.

DCH Medicaid Provider Manual, Practitioner Section,
4.22 Weight Reduction, January 1, 2009

An analysis of the MHP's criteria for Bariatric surgery appears to be consistent with the Medicaid policy listed above. The MHP submitted a copy of its Bariatric Surgery Guidelines which state that the surgery will be approved for a person at least 18 years of age, and a BMI equal to or greater than 35 with two co-morbidities such as poorly controlled diabetes mellitus, sympromatic sleep apnea not controlled by C-Pap, severe cardio-pulmonary condition, inadequately controlled hypertension with optimal conventional treatment, and uncontrolled hyperlipidemia not amenable to optimal conventional treatment. One of the criteria that must be met for individuals with a BMI equal to or greater than 40, with or without co-morbid conditions, is that there must be documented compliance with a weight loss program, including diet, exercise, and behavioral modification for a minimum of one year. (Exhibit 3)

Appellant testified that her [redacted] has a history of hypertension and strokes, she has [redacted] to take care of, and weight loss programs are expensive. Appellant testified that she has a history of losing weight and gaining it back. Appellant joined the Medical Weight Loss Clinic after her request for surgery was denied. Appellant testified that she has lost of total of 6 pounds since joining the weight loss program.

In this case, the Department properly denied Appellant's request for Bariatric/Gastric Bypass surgery. Appellant failed to provide the necessary medical documentation needed to establish that she meets the medical necessity criteria for the surgery. Appellant failed to provide any evidence of documented compliance with a weight loss program, including diet, exercise, and behavioral modification, **for a minimum of one year.** Accordingly, the MHP's eligibility determination must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Medicaid Health Plan properly denied Appellant's request for Bariatric surgery.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Marya A. Nelson-Davis
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/11/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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 receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.