STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-16115 QHP
Case No. [redacted]
Load 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.,* following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] appeared as Authorized Representative for [redacted] (Appellant), who also appeared.

[redacted] appeared on behalf of [redacted] ('Medicaid Health Plan,' or 'MHP'). Also appearing as a witness for the MHP was its [redacted]

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for Revision of a Roux-en-y-Gastric Bypass procedure?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. Appellant is a [redacted]-year old female Medicaid beneficiary, with a medium body frame who weighs [redacted] pounds as of [redacted]. She stands [redacted] tall; her body mass index is 44. *(Exhibit 2, p. 4)*

2. In [redacted], the Appellant underwent Open Gastric Bypass surgery under her [redacted] Employer's insurance coverage. At the time of this procedure, the Appellant weighed [redacted] lbs. Following the [redacted] procedure, the Appellant lost [redacted] lbs. Since her initial weight loss from this surgical procedure, the Appellant has experienced episodes of stomal stenosis, making it necessary to perform stomal balloon dilations in an attempt to correct the complication. *(Exhibit 2, pp. 3; 8; 15-17)*

3. An EGD was performed to examine the measurements of the Appellant's existing stoma site and pouch. At this time it was found that the stoma measured approximately 20 mm, which demonstrates an abnormal enlargement of the stoma. The pouch remained of normal size. *(Exhibit 2, pp. 3; 8)*

4. On [redacted] the Appellant requested prior authorization for a revision of the [redacted] procedure to correct the complications associated with the stoma site. The MHP denied the request, claiming its utilization guidelines limit coverage to one bariatric procedure per lifetime. *(Exhibit 2, p. 34)*

5. The MHP's criteria specifically limits coverage to one bariatric surgical procedure per lifetime, unless medical complications render a revision or reversal of the procedure medically necessary. *(Exhibit 1, p. 9)*

6. On [redacted] the Appellant filed a Request for Hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

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 coverage(s) and limitations. (Emphasis added by ALJ)* 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 coverage(s) 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.

Fee-for-service Medicaid beneficiaries may be approved for obesity-related weight reduction surgery when the following criteria are met.

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.
>
> ***Department of Community Health, Medicaid Provider Manual, Practitioner Version Date: October 1, 2007, Page 40***

A Medicaid beneficiary bears the burden of proving he or she was denied a medically necessary and appropriate service. See, e.g., *J.K By and Through R.K. v Dillenberg*, 836 F Supp 694, 700 (Ariz, 1993). Whether the Appellant satisfies that burden must be determined in accord with the preponderance of the evidence standard. See, e.g., *Aquilina v General Motors Corp*, 403 Mich 206, 210; 267 NW2d 923 (1978).

Proof by a preponderance of the evidence requires that the fact finder believe that the evidence supporting the existence of the contested fact outweighs the evidence supporting its nonexistence. See, e.g., *Martucci v Detroit Police Comm'r*, 322 Mich 270, 274; 33 NW2d 789 (1948).

Regarding an appeal filed with the State Office of Administrative Hearing and Rules for the Department of Community Health, the Administrative Law Judge is given ultimate discretion to determine the weight and credibility of the evidence presented. *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 491; 668 NW2d 402 (2003); *Zeeland Farm Services, Inc v JBL Enterprises, Inc*, 219 Mich App 190, 195; 555 NW2d 733 (1996) (the fact finder is provided with the unique opportunity to observe or listen to witnesses; and, it is the fact finder's responsibility to determine the credibility and weight of the testimony and other evidence provided).

It is the province of the Administrative Law Judge to adjudge the credibility and weight to be afforded the evidence presented. *Maloy v. Stuttgart Memorial Hosp.*, 316 Ark. 447, 872 S.W.2d 401 (1994).

Under its contract with the Department, an MHP is not permitted to deny a procedure based on criteria that would result in the denial of a medically necessary service. An MHP is also not permitted to deny a procedure based on criteria inconsistent, both in content and form, to criteria applicable to fee-for-service Medicaid beneficiaries requesting the same Medicaid-covered service.

Here, the MHP has denied the Appellant's request for revision of a prior bariatric procedure, citing bariatric surgery policy in support of its denial.

The Appellant has requested "revision" of a prior procedure, not bariatric surgery on a first time basis. Thus, the MHP's application of bariatric surgery criterion is inappropriate under these facts.

The Medicaid Provider Manual does not address criterion applicable to "revision" of bariatric procedures. Therefore, if the Appellant satisfies Medicaid medical necessity criterion applicable to surgery, then the MHP's denial cannot stand.

Medicaid surgery policy provides, in pertinent part, as follows:

> **SECTION 12 – SURGERY - GENERAL**
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> Medicaid covers medically necessary surgical procedures.
>
> **12.1 GLOBAL SURGERY**
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> Coverage for the global surgery package includes related services that are furnished by the physician who performs the surgery or by members of the same group with the same specialty. Medicaid policy is based on CMS guidelines for Medicare services for the global surgery package.
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> Global periods are identified on the MDCH Practitioner Medical Clinic Database. The payment rules for global surgery apply to global periods of 000 (only services on the day of the procedure are included), 010 (10-day global period), 090 (90-day global period), and YYY (global period determined on case-by-case basis). Codes with 000 and 010 global periods include endoscopies and minor procedures. Codes with a 090 global period include major surgeries. Codes with an YYY are individually priced and MDCH determines the global period.
>
> **12.1.A. SERVICES INCLUDED IN THE GLOBAL SURGERY PACKAGE**
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> - Pre-operative visits beginning with the day before the surgery for major surgeries and the day of the surgery for minor surgeries.
> - Intra-operative services that are a usual and necessary part of a surgical procedure.
> - *Complications following surgery. This includes all additional medical or surgical services required of the surgeon during the post-operative period due to complications that do not require return to the operating room. The surgeon's visits to a patient in an intensive care or critical care unit are also included. (Emphasis supplied by ALJ)*

- Follow-up visits within the post-operative period related to recovery from the surgery.
- Post-surgical pain management by the surgeon.
- Supplies for certain services furnished in a physician's office.
- Miscellaneous services and items such as dressing changes, local incisional care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes, and changes and removal of tracheostomy tubes.

12.1.B. SERVICES NOT INCLUDED IN THE GLOBAL SURGERY PACKAGE

- The surgeon's initial consultation or evaluation of the problem to determine the need for surgery.
- The office or hospital visit to decide upon surgery if it occurs on the day before or the day of a major surgery.
- Other physicians' services, except when the surgeon and the other physician(s) agree on the transfer of care (The transfer of care agreement may be in the form of a letter or an annotation in the discharge summary, hospital records, or ambulatory surgical center records).
- Visits unrelated to the diagnosis for which the surgical procedure was performed.
- Treatment of the underlying condition or an added course of treatment that is not part of the normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiology procedures.
- Clearly distinct surgical procedures that are not repeat procedures, or treatment for complications during the post-operative period. A new post-operative period begins with the subsequent procedure.
- Staged procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples include procedures to diagnose and treat epilepsy in succession within 90 days of each other.
- Laser eye surgeries (and all other services whose CPT/HCPCS description includes one or more sessions) performed in a series over a period of weeks or months are not considered staged procedures. All sessions during the post-operative period of the first session are covered as a part of the global package.
- Chemotherapy and/or radiation therapy following cancer surgery.
- Treatment for post-operative complications that requires a return to the operating room. For this purpose, an operating room is a place of service specially equipped and staffed for the sole purpose of performing surgical procedures, including a cardiac catheterization suite, a laser suite, and an endoscopy suite. Not included is a patient's room, a minor treatment room,

a recovery room, or intensive care unit unless the patient's condition is so critical there is insufficient time for transportation to an operating room.

- A second, more extensive procedure when a less extensive procedure fails.
- A therapeutic service that is required during the post-operative period of a diagnostic service. Example: A D&C followed by a therapeutic hysterectomy performed during the D&Cs global period.
- Immunosuppressive therapy for organ transplants.
- Critical care services unrelated to the surgery when a seriously injured or burned patient is critically ill and requires constant attendance of the physician.
- Visits that are a significant, separately identifiable service on the same day as a minor surgery or endoscopy. For example, a visit for a full evaluation of a lump in the breast on the same day as a removal of a lesion on the back.
- When a beneficiary is returned to the operating room for treatment of complications, only the intra-operative portion of the service is covered.

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The Appellant's physician credibly testified the Appellant has experienced major complications from her original [redacted] bariatric surgery, a situation which has resulted in the Appellant's weight gain, despite following dietary restrictions. The Appellant's physician also credibly described that the revision is not an entirely new procedure, but rather, is a procedure designed to repair the stoma, and, if necessary, the pouch.

The MHP simply relied on its belief that, because of the significant period of time between [redacted] and the present, the Appellant's request is for bariatric surgery.

The above-cited surgery policy appears inconsistent with regard to non-covered services. Policy indicates that treatment for post-operative complications is not covered when the patient is returned to the operating room. Yet, policy also provides that, when a beneficiary is returned to the operating room for treatment of complications, only the intra-operative portion of the service is covered.

Thus, it appears that coverage is available for the intra-operative portion of the revision procedure requested.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I decide the MHP has inappropriately denied the Appellant's prior authorization request for revision of gastroplasty.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is REVERSED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5/26/2009

***** 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.