STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2009-17374 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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant appeared without representation, she had no witnesses. [redacted] represented the represented the Medicaid Health Plan (MHP). His witness was [redacted], [redacted].

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for laparoscopic gastric bypass 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], since [redacted]. (Appellant Exhibit #1, p. 6)

2. The Appellant is a [redacted] who weighs 302 and has a BMI of 47. She is afflicted with morbid obesity, HTN, cardiomyopathy, NIDDM, CHF, GERD and herniated disc with chronic back pain. (See Testimony, and Appellant's Exhibit #1, p. 9)

3. On [redacted], the MHP received the Appellant's request for PA of Bariatric surgery from the Appellant's physician, [redacted], [redacted]. (Respondent Exhibit A, p. 2)

4. On [redacted] the request was forwarded to the MHP Associate Medical Director for review.

5. The request was denied following review for lack of clinical documentation (Respondent Exhibit A, p. 1)

6. The MHP Associate Medical Director determined that the Appellant did not meet approval criteria as she provided no timely documentation of attendance in a physician supervised weight loss program, or member demonstration of regular attendance in such a program supervised by a plan physician. She provided no records of a physician examination and finally presented no evidence of a laboratory evaluation to rule out other treatable causes of her morbid obesity. (Respondent's Exhibit A, pp. 1-20 and See Testimony of [redacted])

7. The Appellant testified that she thought her physican was taking all of the right steps. (See Testimony)

8. On [redacted], the MHP advised the Appellant, in writing, that her request for Bariatric surgery was denied because she did not meet coverage criteria. She was further advised of her appeal rights. (Respondent Exhibit A, pp. 2, 3)

9. The instant request for hearing was received by SOAHR on March 30, 2009. (Appellant's Exhibit #1)

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 I-Z.
>
> Article II-G, Scope of Comprehensive Benefit Package, Contract, 2008, p. 32.

> 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 utilization management activities of the Contractor must be integrated with the Contractor's QAPI program.
>
> 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.
>
> *Supra*, Contract, §II-P p. 66.

The MHP witness further elaborated that the MHP Bariatric surgery policy is consistent with Medicaid policy.

The Michigan Medicaid Provider Manual (MPM) policy related to weight reduction is as follows:

[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.
>
> MPM, Practitioner §4.22, January 1, 2009, page 38.

The Appellant testified that she had been morbidly obese for a long time [12 years] and that she had been maintaining food diaries and utilizing weight loss groups without success. She added that she thought she met all of the criteria and that her doctor had “handled” the process.

The MHP witness explained that on utilization review the material which her physican submitted was inadequate for lack of a laboratory evaluation and lack of medical records of the Appellant on medical examination - as opposed to a summary letter. [redacted] said that the MHP was interested in laboratory work ruling out thyroid disease.

The Petitioner has the burden of proving by a preponderance of evidence that she met the Medicaid policy criteria for coverage of Bariatric surgery. The MHP witness testified that they considered all of Appellant's medical documentation for Bariatric surgery in accordance with Medicaid policy and its MHP policy. They established that Appellant had failed to submit adequate required documentation as discussed above.

As of the date of review the MHP properly denied the request for Bariatric surgery.

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.

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/24/2009

***** 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.