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. 2009-24847 QHP
Case No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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 completed [redacted]. The hearing was begun by ALJ Maleska and continued by ALJ Isiogu. The recording of the initial phase of the hearing was listened to in its entirety by ALJ Isiogu prior to convening the hearing on [redacted].

[redacted] represented herself at hearing.

[redacted] represented the Medicaid Health Plan (MHP) at hearing. [redacted] appeared as a witness on behalf of the health plan. [redacted] was also present.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for revision of the Appellant's Lap Band procedure?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] female Medicaid beneficiary. She is [redacted] in height with a BMI of [redacted]. She has diabetes, CAD, degenerative joint disease, cirrhosis of the liver and fatty liver disease.

2. The Appellant had a gastric lap band placement in [redacted]. She subsequently lost 70 lbs. She endured complications following surgery and it was discovered her port had flipped. The port was revised and the Appellant thereafter developed an infection at the port cite.

3. The infection at the Appellant's port cite has healed completely.

4. The Appellant has regained approximately 35 lbs recently.

5. The Appellant seeks removal of the gastric band and revision of the operation to what is referred to as a gastric sleeve.

6. The Appellant asserts the procedure is necessary as a remedy to a complication of her original surgery. She cites difficulty swallowing and upper GI results indicating she has delayed emptying of the pouch following eating as ongoing complications that require removal of the lap band.

7. The MHP denied the request for revision of her lap band, citing [redacted] guidelines for weight reduction surgery limiting it to one procedure per lifetime, unless necessary to correct a surgical complication.

8. The Appellant submitted documentation from [redacted], dated [redacted], describing the Appellant's history with the gastric surgery and her current medical condition. The letter states in part, "the significant problem now is she is has difficulty swallowing solids and liquids. Since the port revision the band is sitting around the stomach in a neutral position. Due to risk factor we can't adjust the band anymore because she is having difficulty swallowing and I don't think the band is gong to work for her. It would be dangerous to try to adjust the band given the complications with swallowing; this could damage the esophagus. Upper GI was performed in [redacted], which showed that she has delayed emptying of the band. …This patient has co-morbid conditions that could be reduced or resolved with a bariatric procedure. She has hypertension, degenerative joint disease, diabetes type 2, fatty liver disease and cirrhosis of the liver."

9. The Appellant does not currently have uncontrolled co-morbidities.

10. The MHP denied the Appellant's request for removal of her lap band and conversion to a gastric bypass sleeve on or about [redacted].

11. The Appellant requested a formal, administrative hearing [redacted].

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

Under its contract with the Department, the MHP is not permitted to deny a procedure based on criteria that would result in the denial of a medically necessary service. The MHP is also not permitted to deny a procedure based on criteria that is inconsistent with 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 it's own guidelines for bariatric surgery, which denies the procedure more than once per lifetime, unless a surgery is needed to correct or reverse a previous bariatric procedure from complications.

This ALJ finds this is inconsistent with the policy set forth in the Medicaid Provider Manual which does not limit a bariatric procedure to one per lifetime. They are only covered to address life threatening conditions that cannot otherwise be addressed, but there is no limitation to one per lifetime. The denial on this basis is not supported by the controlling policy. However, this does not render the request approvable. The Appellant must establish the procedure is medically necessary under the criteria. The criteria states the procedure is done not to address weight alone, it is done to address uncontrolled co-morbidities.

The Appellant has requested her lap band be removed and to undergo a gastric sleeve by pass surgery. She presented documentation from her physician in support of the request. A careful review of the documentation submitted does not establish removal of the lap band is medically necessary. There is no clear evidence the lap band is causing medical problems for the Appellant. Her physician stated he does not believe it is going to work for her. This is not a complication from surgery that requires correction. While it would no doubt be desirable to have it removed if it's not working, nothing in the documentation submitted indicates the band must be removed to address a medical complication the Appellant is having at this time.

The documentation and testimony were reviewed for evidence of an uncontrolled co-morbidity. There was none. The Appellant suffers diabetes type II, however, it is not uncontrolled according to the evidence of record. She may begin to take medication again in the future. This is not evidence the medical condition is uncontrolled. There was no evidence presented the Appellant's requested surgical procedure meets the criteria set forth in the Medicaid Provider Manual. She failed to meet her burden of proof.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I find the Appellant has not established the requested revision of her bariatric surgery is medically necessary, thus the denial from the MHP is appropriate.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

[redacted]
Docket No. 2009-24847 QHP
Decision and Order

[redacted]

Date Mailed: 9/1/2009

***** 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.