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. 2009-33348 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.,* following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted] (Appellant) appeared and testified on his own behalf.

[redacted] Grievance Coordinator, appeared on behalf of [redacted] ('Medicaid Health Plan,' or 'MHP'). Also appearing as a witness for the MHP was [redacted] Grievance and Quality Review Specialist, and Registered Nurse.

ISSUE

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

FINDINGS OF FACT

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

1. Appellant is a [redacted] Medicaid beneficiary who stands 70 inches and weighs 319 lbs. On [redacted], the MHP received a fax request from [redacted] requesting coverage of bariatric surgery. *(Exhibit 1; p. 3)*

2. On [redacted], the MHP's Medical Director reviewed the Appellant's medical record(s) and the request for bariatric surgery and determined the surgery was not a covered benefit because he did not meet requirements as articulated in the Medicaid Provider Manual (MPM).

3. On [redacted], the MHP sent the Appellant a letter advising him the request for coverage had been denied. The letter stated: *"…records state that you are overweight, have high blood pressure, coronary artery disease (CAD), sleep apnea (you stop breathing for short periods when you sleep) and Gastroesophageal Reflux Disease (GERD). Problems that may be life-endangering are high blood pressure or high blood sugar not controlled with medicine. Your high blood pressure and CAD are being controlled with medicine. Your sleep apnea and GERD are not considered life endangering. The records sent by your doctor, do not support that you have life-endangering complications."* (Exhibit 1; p. 3)

4. On [redacted] the MHP received another request from the Appellant for coverage of bariatric surgery. On [redacted], an acknowledgement letter was mailed to the Appellant advising him that he had initiated the grievance process. It also advised him that he would be notified in writing of the decision, and if the decision remained a denial of coverage, he would be invited to attend a hearing on [redacted].

5. On [redacted], the MHP sent the Appellant a letter advising him that his request for coverage of bariatric surgery was denied; because it was determined his condition did not meet MPM guidelines. On [redacted], [redacted], a hearing with the MHP's Grievance Committee occurred.

6. On [redacted], the MHP sent the Appellant a letter informing him that his request for coverage of bariatric surgery was again denied, asserting he did not meet MPM guidelines.

7. An [redacted], letter from [redacted] Thoracic Cardiovascular Institute, provides the following information:

> *"..Paul has been a patient of mine for some time, and has been battling issues of coronary artery disease, hypertension, obstructive sleep apnea, as well as morbid obesity. He has been trying to get insurance coverage for some form of bariatric weight loss surgery including lap band surgery. His morbid obesity contributes to his comorbidities; in particular, his hypertension which has been difficult to control, his coronary artery disease, and his sleep apnea. At his most recent evaluation with me his weight was 309 pounds, with a body*

> *mass index of 44.3. In younger patients like him, who are not able to lose weight in other way[s], it is not unreasonable to consider bariatric surgery. A lap band procedure that might be less invasive might be more helpful to him given his coronary artery disease and history of angioplasty and stenting. I am in general supportive of a procedure like this for him if it can be accomplished, cognizant of the constraints financially. In the long run, however, it might be cheaper to consider procedures like this on specific patients, rather than to pay all of their medical costs over the ensuing years."*
>
> *" . . ."*
>
> *(Exhibit 1; p. 45)*

8. 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, 2009, Page 39***

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).

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).

Here, the MHP has denied the Appellant's request for bariatric surgery, citing MPM bariatric surgery and internal coverage policy in support of its denial. 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.

The Appellant provided medical documentation, dating to [redacted]. A majority of the documentation pertains to the Appellant's pulmonary issues and chronic cough syndrome for which conventional treatment has apparently been unsuccessful. None of this documentation addresses criterion applicable to MPM bariatric surgery policy, other than perhaps the [redacted] documentation referencing the Appellant's chronic hypertension and body mass index.

MPM bariatric surgery policy specifically excludes coverage when utilized for weight reduction purposes only. Bariatric surgery is a covered procedure only when performed to control life-endangering co-morbidities such as uncontrolled hypertension or diabetes. The medical evidence presented indicates the Appellant's blood pressure is not ideal. However, it also does not appear to be elevated to life-endangering levels, likely because it is

somewhat controlled with medication. *(Exhibit 1; pp. 9-10)*

The Appellant has also produced no evidence of his participation in conservative weight loss programs although it appears from the record his pulmonary issues may impact his ability to engage in strenuous exercise. *(Exhibit 1; p. 41)* Nonetheless, policy specifically requires evidence of such measures, as well as a psychiatric evaluation to determine potential compliance with post-surgical dietary restrictions, neither of which has been presented for consideration.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

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

cc: [redacted]

Date Mailed: 11/20/2009

***** 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.