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. 2010-14826 QHP
[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] appeared on her own behalf. [redacted], [redacted], represented the Medicaid Health Plan (MHP) Health Plan of Michigan. [redacted] and [redacted], appeared as witnesses for the MHP. [redacted], was present but did not participate.

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 enrolled in the [redacted], a Medicaid Health Plan (MHP) in [redacted].

2. The Appellant is a female, 5'6" height, with a weight of approximately 440 pounds and a BMI of 70. (Exhibit 1, page 7, 10-13).

3. On [redacted], the MHP signed the Appellant's Letter of Commitment for Healthyroads Weight Coaching Program. (Exhibit 1, page 7).

4. On [redacted], the MHP received via facsimile the Appellant's Letter of Commitment, several pages of doctor clinic notes and a letter of medical necessity for bariatric surgery from Appellant's physician assistant. (Exhibit 1, pages 8 - 13).

5. On [redacted], the MHP sent a letter to the Appellant stating that the request for bariatric surgery was denied because she did not meet coverage criteria. The MHP letter stated that Appellant had not completed six months in the [redacted] program and six continuous months in an approved, medically supervised weight loss program. (Exhibit 1, pages 15-18).

6. The Appellant's denial went before the MHP grievance-appeal committee. (Exhibit 1, page 19). On [redacted], the MHP sent Appellant notification that the appeal committee upheld the original denial because she had not completed six months in the [redacted] program and six months of a physician-supervised weight loss program. (Exhibit 1, pages 21-22).

7. On [redacted], the Appellant submitted a Request for Administrative Hearing. (Exhibit 1, page 6).

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. MDCH contract (Contract) with the Medicaid Health Plans, Final FY 2008 Contract, 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.
>
> *Article II-P, Utilization Management, MDCH Contract, Final FY 2008 Contract, p. 66.*

MHP Witness Firsht indicated that the MHP bariatric surgery policy is consistent with Medicaid policy. Witness [redacted] explained that its criteria for coverage of bariatric surgery requires completion of six months in the [redacted] program and at least six

months of an MHP approved, physician supervised, weight loss program before authorization of bariatric surgery. MHP witness [redacted] explained that Appellant's request for bariatric surgery had no documentation of six months in the [redacted] program and six months completion of a medically-supervised weight loss program. Because the Appellant had no documentation of two of the criteria needed for bariatric surgery authorization, the MHP said it denied the authorization.

The Michigan Medicaid policy related to weight reduction 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. (Emphasis added by ALJ).
>
> *MDCH Medicaid Provider Manual, Practitioner Section, January 1, 2010, pages 39-40*.

An analysis of the MHP's criteria for bariatric surgery concludes that it is consistent with the Medicaid policy listed above. (Exhibit 1, pages 23-24). A review of the documentation sent in by Appellant's health care provider as part of the request for bariatric surgery authorization showed that Appellant did not have documentation of a conservative method of weight loss, for example, a medically supervised weight loss program.

The Appellant testified that she understands she must complete six months in a medically-supervised weight loss program. The Appellant explained that a woman whose name she could not recall told her that if her doctor wrote a letter she may be able to receive bariatric surgery sooner than the completion of six months of the [redacted] program and six months of a medically-supervised weight loss program. MHP testimony and documents established Appellant is now enrolled in the [redacted] program, effective [redacted]

The MHP established that Appellant had not demonstrated the required documentation of compliance with a medically-supervised weight loss program. The Appellant bears the burden of proving, by a preponderance of the evidence that she met all of the criteria for coverage of bariatric surgery. The Appellant did not meet the burden, having failed to provide evidence that she had complied with [redacted] and a medically-supervised weight loss program. Thus, the MHP properly denied the request for bariatric surgery because from the medical documentation provided, all criteria were not met.

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.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/12/2010

***** 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.