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. 2010-30818 QHP
[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 held [redacted]. The Appellant, [redacted], appeared on her own behalf. [redacted], Director of Medicaid, represented [redacted], the Medicaid Health Plan.

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. The Appellant is a [redacted] female Medicaid beneficiary who is currently enrolled in [redacted], a Medicaid Health Plan (MHP).

2. On [redacted], the MHP received a request for bariatric surgery from the Appellant's physician. The Appellant's body mass index (BMI) was documented as 41.8 and no co-morbidities were indicated by the physician. (Exhibit 1, page 7)

3. On [redacted], the MHP sent the Appellant a denial notice, stating that the request for bariatric surgery was not authorized because the submitted

clinical documentation did not establish all criteria for the procedure had been met. Specifically, the Appellant has no qualifying obesity-related co-morbidities. (Exhibit 1, pages 9-10)

4. The Appellant requested a formal, administrative hearing contesting the denial on [redacted] (Exhibit 1, page 4)

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 MHPs.

The Respondent is one of those MHPs.

> 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. The Contractor 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 2.024.
>
> *Section 1.022(E)(1), Covered Services.*
> *MDCH contract (Contract) with the Medicaid Health Plans,*
> *October 1, 2009.*

> (1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:

(a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
(b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
(e) The Um activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure
The Contractor must establish and use a written prior approval policy and procedure for UM 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Section 1.022(AA), Utilization Management, Contract, October 1, 2009.

As stated in the Department-MHP contract language above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent section of the Michigan Medicaid Provider Manual (MPM) states:

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: April 2, 2010, Pages 39-40*

The DCH-MHP contract provisions allow prior approval procedures for UM purposes. The MHP representative explained that for a procedure such as bariatric surgery, the MHP requires prior approval. In order to achieve prior approval, it was further explained that specific criteria must be met. For an individual with a BMI greater than or equal to 40, the individual must also suffer from at least one qualifying obesity-related co-morbidity. (Exhibit 1, pages 12-14) There are four qualifying co-morbidities:

- Symptomatic sleep apnea (AHI>10) requiring treatment
- Significant cardiac disease (e.g. ASHD, RVH or LVH)
- Hypertension on one or more medications
- Hyperlipidemia (>30mg/dl above goal) on maximum dose of monotherapy
- Diabetes with Hgb A_1C >7.0 on one or more medications

(Exhibit 1, page 14)

On the prior authorization request, the Appellant's physician noted that the Appellant did not suffer from any co-morbidities. (Exhibit 1, page 7) And the Appellant does not dispute this fact. But she indicated that she is unable to lose weight on her own. She testified that she had gained weight since the prior authorization request was made, and she asked the MHP for help. The MHP did offer to provide the Appellant with a nutritionist.

The MHP's bariatric surgery prior approval process is consistent with Medicaid policy and allowable under the DCH-MHP contract provisions. The MHP demonstrated that, based on the submitted information, the Appellant did not meet the criteria for approval of bariatric surgery. As such, the MHP properly denied prior approval of this procedure.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied the Appellant's request for bariatric surgery.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 6/9/2010

***** 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.