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

Docket No. 2010-32862 QHP
Case No. [redacted]

[redacted]

Appellant
_____/

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]. [redacted] appeared on her own behalf. [redacted], Director of Medicaid, represented Priority Health, the Medicaid Health Plan (hereinafter MHP).

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] year old female Medicaid beneficiary who is currently enrolled in Priority Health, a Medicaid Health Plan (MHP).

2. On [redacted], the MHP received a request for bariatric surgery from the Appellant's physician. The Appellant's BMI was documented as 49.2 and symptomatic sleep apnea was the only obesity related co-morbidity indicated by the physician. (Exhibit 1, page 9)

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 participation in a weight management program with an approved provider for at least 6 months, or having qualifying co-morbidities. (Exhibit 1, pages 7-8)

4. On [redacted], the Appellant requested a formal, administrative hearing contesting the denial. (Exhibit 2)

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.*

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 1, 2010, Pages 39-40*

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP representative and MHP witness 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 45 but less than 55, the criteria include one qualifying obesity related co-morbidity or documentation of active participation and compliance in an approved weight management program for at least 6 months. (Exhibit 1, page 14)

The MHP testified that the information submitted with the request for did not show that a qualifying obesity related co-morbidity was present. There are four qualifying co-morbidities:

- Significant pulmonary disease (e.g. Pickwickian Syndrome, pulmonary hypertension)
- Significant cardiac disease (e.g. ASHD, RVH or LVH)
- Hypertension requiring triple therapy
- Diabetes with Hgb A_1C >7.0 and either triple therapy or insulin

(Exhibit 1, page 114)

The only co-morbidity indicated by the Appellant's physician on the prior authorization request was symptomatic obstructive sleep apnea, which is not one of the qualifying co-morbidities listed above. (Exhibit 1, page 9) The Appellant testified that she has a history of COPD requiring nebulizer treatments and was recently diagnosed with high cholesterol. However, no documentation of COPD or any other significant pulmonary disease was submitted to the MHP. The Appellant also testified that so far she has been put on a special diet for high cholesterol, but has not been prescribed any medications to treat this condition.

The MHP further testified that the Appellant did not meet the requirement of participating in an approved weight management program for at least 6 months. The MHP noted that the Appellant does qualify for the weight management program. The Appellant testified that she looked into the weight management program but was told she would only be approved for 12 weeks, and noted she does not have a vehicle to go to [redacted] for the program. The MHP explained that they approve 12 weeks at a time, and then request progress notes to evaluate ongoing authorization. The MHP testified that they cover transportation assistance as well; they just need five days advance notice.

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 criteria for approval of bariatric surgery. As such, the MHP properly denied prior approval of this procedure. However, this does not imply that the Appellant will never qualify for this procedure. The Appellant may wish to submit a new prior authorization request for this procedure upon completing 6 months in the weight management program or with medical documentation of a qualifying co-morbidity that would waive the participation requirement.

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.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 7/16/2010

***** 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.