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:

Docket No. 2010-32867 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], Appeals Coordinator, represented [redacted] Healthcare of Michigan, the Medicaid Health Plan. [redacted], Medical Director, appeared as a witness for the 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 [redacted] Healthcare of Michigan, a Medicaid Health Plan (MHP).

2. On [redacted], the Appellant underwent surgical placement of a laparoscopic adjustable gastric band. (Exhibit 1, pages 20-21)

3. The Appellant successfully lost weight with the lap band. (Exhibit 1, pages 14 and 19)

4. On [redacted], the Appellant's lap band was removed because it had slipped. (Exhibit 1, page 14)

5. On [redacted], the MHP received a request for laparoscopic gastric banding surgery from the Appellant's physician. The Appellant's medical conditions include diabetes, sleep apnea, hyperlipidemia and arthritis. The physician reported a height of 5'2", weight of 160 pounds and BMI of 29.3. (Exhibit 1, pages 13-14)

6. On [redacted], the MHP sent the Appellant and her doctor a denial notice stating that the request for laparoscopic adjustable gastric banding surgery was not authorized because the submitted notes did not show attendance and weight loss with a physician supervised weight loss program for at least one year and done within the past two years. The denial also noted that there is a benefit limit of one procedure per lifetime and that the Appellant had laparoscopic band surgery in [redacted]. (Exhibit 1, pages 4-5)

7. On [redacted], the Appellant telephoned the MHP requesting an appeal of the denial. (Exhibit 1, page 11)

8. On [redacted], the MHP sent a letter to the Appellant indicating that the Appeal Review Committee also denied the request for laparoscopic adjustable gastric banding. (Exhibit 1, pages 23-26)

9. On [redacted], the Appellant requested a formal, administrative hearing contesting the denial. (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 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: October 1, 2009, Page 39*

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. The MHP submitted their Utilization Guideline outlining the indications and required criteria, which includes a BMI over 35. (Exhibit 1, pages 6-9) This criterion is also included in the Michigan Association of Heath Plans Bariatric Surgery Guidelines for Coverage. (Exhibit 1, pages 2-3) The documentation submitted by the Appellant's physician indicates a height of 5"2", weight of 160, and BMI of 29.3. (Exhibit 1, page 13) Accordingly, the Appellant would not qualify for bariatric surgery because her BMI is under 35.

The Appellant testified that she actually weighs almost 200 pounds. Since the BMI calculation utilized height and weight, the Appellant's BMI would be higher using a weight of 200 pounds instead of 160 pounds. However, the last weight documented in the Appellant's physician's progress notes was 167 pounds on [redacted]. There is no medical documentation of a current weight close to 200 pounds.

The MHP criteria further requires physician documented successful participation in a physician supervised weight loss program, including weight loss diet, exercise, and behavior modification for at least one year within the past two years. (Exhibit 1, page 6) This criterion is similar to Michigan Association of Heath Plans Bariatric Surgery Guidelines for Coverage requiring compliance with a weight loss program for a maximum of one year. (Exhibit 1, page 2) The Appellant lost weight with the lap band before it was removed in [redacted]. (Exhibit 1, pages 14 and 19) However, none of the submitted documentation showed that the Appellant has recently participated in a physician supervised weight loss program involving diet, exercise, and behavior modification.

Based on the evidence, the Appellant has not met the BMI or weight loss program requirements for bariatric surgery. Accordingly, there is no need for this ALJ to address the one procedure per lifetime benefit limitation.

The MHP's bariatric surgery prior approval process, requiring a BMI over 35 and participation in a physician supervised weight loss program 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.

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.