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. 2010-45592 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]. [redacted] appeared on behalf of the Appellant. She had no witnesses. [redacted] appeals coordinator, represented the Medicaid Health Plan (MHP). Her witness was Medical Director, [redacted]

PRELIMINARY MATTER

At the close of proofs the Appellant's representative sought admission of notes from [redacted] dated [redacted]. The ALJ took the admission of this material under advisement and now rules it admissible – but cumulative to the evidentiary record and the testimony. Appellant's Exhibit #2 [doctor note] is admitted.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for a sleeve gastrectomy?

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 who was enrolled in [redacted], since [redacted]. (Appellant Exhibit #1)

2. The Appellant is a [redacted]d who weighs [redacted] pounds. He is afflicted with poorly controlled DM, severe cardio pulmonary condition, seizure disorder/schizophrenia, MR, OSA, epilepsy, renal failure, gouty arthritis with b-pap and trach. (See Testimony, and Respondent's Exhibit A, pp. 9, 11, 13, 14, 16)

3. On [redacted], the MHP received the Appellant's request for PA of sleeve gastrectomy surgery from the Appellant's physician, [redacted] (Respondent Exhibit A, pp. 2, 3, 12)

4. On [redacted], following internal review, the Surgical Review Committee upheld the denial decision for lack of a 12-month physician supervised weight loss program demonstrating weight loss or stability over the last 24-month period. (See Testimony and Respondent's Exhibit A, pp. 1, 2)

5. The Appellant was notified of the original denial on [redacted] and then the Committee denial on [redacted]. His further appeal rights were transmitted in writing. (Respondent's Exhibit A, pp. 1, 41, 42)

6. The instant request for hearing was received by SOAHR on [redacted]. (Appellant's Exhibit #1)

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. 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.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support

- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for persons under age 21

Article 1.020 Scope of [Services], at §1.022 E (1) contract, 2010, p. 22.

The Michigan Medicaid Provider Manual (MPM) policy related to weight reduction is as follows:

[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.
>
> MPM, Practitioner §4.22, October 1, 2010, pp. 39-40.[1]

***

[1] This edition of the MPM is identical to version in place at the time of appeal.

The Appellant's representative testified that her son weighs [redacted] pounds and has been trying to diet for [redacted] without success. She said his weight would frequently vary month to month by six to seven pounds. She said she is desirous of trying "anything and everything" to help her son. She added that the bariatric surgeon, [redacted], said that the Appellant is competent[2] to understand to the post surgical routine.

The MHP witness, [redacted], said that there was no evidence that the Appellant was a good candidate for the sleeve gastrectomy – in part owing to the lack of the required psychological evaluation and his inability to understand both the surgery and the post surgical restrictions.

On review of the evidence it was further discovered by the ALJ that the Appellant was excluded from the requested surgical procedure owing to his diagnosis of schizophrenia. [*See* Utilization Guidelines and doctor note at Respondent's Exhibit A, at pages 7 and 16]

The Appellant has the burden of proving by a preponderance of evidence that he met the policy criteria for coverage of the requested sleeve gastrectomy surgery. The MHP witness testified that they considered all of Appellant's medical documentation for this surgery in accordance with Medicaid policy and its MHP policy. An internal review by the Surgical Review Committee affirmed the original decision to deny. The Respondent established that Appellant had failed to demonstrate by way of adequate documentation that he had participated in a 12-month, physican supervised, weight loss program.

Furthermore, the Appellant has a disqualifying diagnosis of schizophrenia.

As of the date of review the MHP properly denied the request for sleeve gastrectomy surgery.

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 sleeve gastrectomy surgery.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

_____
Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

[2] This was disputed by the MHP.

cc: [redacted]

Date Mailed: _____

***** 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.