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. 2010-47810 QHP

[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 on [redacted]. The Appellant, [redacted], was present. [redacted], Certified Physician Assistant, represented the Appellant. [redacted], RN/Clinical Appeals, represented [redacted], the Medicaid Health Plan (MHP). [redacted] RN/Team Lead with Medical Management, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny the Appellant's request for bariatric surgery?

FINDINGS OF FACT

Based on the competent, material, and substantial evidence presented, the ALJ finds, as material fact:

1. The Appellant is a [redacted] male Medicaid beneficiary, who is currently enrolled in [redacted], a MHP.

2. On [redacted], the MHP received a request for bariatric surgery from the Appellant's surgeon. The Appellant's body mass index (BMI) was documented as 46.3 as of [redacted] and "multiple" co-morbidities were indicated by the surgeon. (Exhibit 1, pages 2-4)

3. On [redacted] and [redacted] the MHP contacted the Appellant's surgeon to obtain additional information regarding the Appellant's co-morbidities. However, no additional information was received. (Exhibit 1, pages 18-19;Testimony of [redacted]

4. On [redacted], the MHP sent the Appellant and his surgeon a denial notice, stating that request could not be authorized because the submitted documentation did not describe a multi-disciplinary approach to preparing and managing the pre- and post-operative care of the Appellant and it did not show any co-morbidity that is not well controlled after medical treatment. (Exhibit 1, pages 37-45)

5. On [redacted], the Appellant's surgeon appealed the denial, noting that a multi-disciplinary had been submitted to the MHP and that the Appellant's primary care notes indicated his ongoing problems with co-morbidities. (Exhibit 1, page 46)

6. On [redacted], the MHP denied the Appellant's surgeon's appeal. It again asserted that there was no documentation to support that the Appellant's co-morbidities are not well controlled. (Exhibit 1, page 48)

7. The Appellant requested a formal, administrative hearing contesting the denial on [redacted].

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 [redacted], 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 1, 2010, Pages 39-40

The DCH-MHP contract provisions allow prior-approval procedures for UM purposes. The MHP explained that for bariatric surgery, the MHP requires prior approval. In order to achieve prior approval, the surgery must be deemed medically necessary. To prove medical necessity, specific criteria must be met. For example, if the individual has a BMI between 40 and 50, which the Appellant here does, then he must show that he suffers from "[one] or more significant co-morbidities not well controlled with appropriate treatment that a surgical weight loss treatment is likely to improve." (Exhibit 1, page 20). More specifically, the co-morbity must be "poorly controlled on appropriate medical therapy and would likely improve with weight reduction OR by virtue of family history and existing clinical conditions, the patient would remain high risk for short term co-morbid complications without surgery." The MHP's policy provides the following as examples:

- Poorly controlled hypertension on multi-drug therapy
- Inadequately controlled diabetes despite high dose insulin treatment and other therapeutic regimens

- Lipid disorder and maximum drug therapy and lifestyle modification without control.

(Exhibit 1, page 21)

Here, the Appellant's representative testified that the Appellant was referred to the surgeon by his primary care physician (PCP) in [redacted] for bariatric surgery. He further testified that the Appellant suffers from the following significant co-morbidities, which he believes would entitled the Appellant to the surgery: obstructive sleep apnea with resulting major fatigue; history of stroke; and uncontrolled diabetes. However, the Appellant's representative admitted that he has no knowledge that any of the documentation to support this information was submitted to the MHP. He further stated that the Appellant suffers from hypertension and hypolipidemia, but both are controlled by medications.

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. However, the Appellant may submit a new request with supporting documentation at any time.

DECISION AND ORDER

The ALJ, 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: 11/9/2010

***** 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.