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]

Docket Nos. 2010-52494 QHP

[redacted]

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge 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], appeared on her own behalf. [redacted], Grievance Supervisor, represented [redacted], the Medicaid Health Plan (MHP). [redacted], Registered Nurse/Quality Review Specialist, and [redacted], Executive Medical Director, appeared as witnesses 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 Administrative Law Judge finds, as material fact:

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

2. On [redacted], the MHP received a request for bariatric surgery from [redacted] Weight Management. The Appellant's body mass index (BMI) was documented as 61.1, and the co-morbidities of hypertension, diabetes, sleep apnea, and GERD were indicated. (Exhibit 1, page 7)

3. On [redacted], the MHP sent the Appellant a denial notice, stating that her request for bariatric surgery was not authorized because the submitted clinical documentation did not establish that all criteria for the procedure had

been met. Specifically, because the Appellant's co-morbidities are controlled by conservative treatment, i.e., use of medications and a CPap machine, she does not suffer from any life-endangering complications as required by Medicaid policy. (Exhibit 1, pages 64-66)

4. The Appellant requested a formal, administrative hearing contesting the denial on [redacted]. (Exhibit 1, page 68)

5. The MHP treated the Appellant's request for hearing as an internal appeal. A hearing was held on [redacted]. (Exhibit 1, pages 71, 78)

6. On [redacted] the MHP sent the Appellant a second denial letter, noting the same reasons for its denial. (Exhibit 1, pages 79-80)

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: July 1, 2010, pages 39-40*

The MHP's Executive Medical Director testified that the Appellant's request for bariatric surgery was denied because the Appellant does not have any life-threatening complications as required by the Medicaid Provider Manual. He explained that while the Appellant's medical records do support that she suffers from hypertension, diabetes, and sleep apnea, these condition are all well controlled by conservative treatment, i.e., the use of medications and a CPap machine. Therefore, they are not life threatening. He further stated that because the Appellant's conditions are well controlled, bariatric surgery in this case would be solely for the treatment of obesity or weight reductions alone, which is expressly prohibited by the Medicaid Provider Manual.

Conversely, the Appellant testified that her medical conditions are not well controlled. She stated that her CPap is not working for her, her glucose numbers keep rising, and her blood pressure keeps going up. She explained that she needs the surgery because she cannot breathe, and because she has other medical issues that require surgery, but she cannot have the surgery because of her weight. However, the Appellant admitted that she smokes, which also contributes to her breathing problems.

There was no medical documentation in the record to support that any of the Appellant's conditions are not well controlled. Indeed, the sleep study submitted to the MHP indicated that the Appellant's incidences of decreased breathing were reduced to one per hour while wearing her CPap, and a normal amount is anything less than five. In addition, the Appellant's dosage for her diabetes is considered sub-therapeutic. In other words, it could be increased for effective control of her diabetes if needed. Finally, there is nothing in the medical documentation to support that the Appellant is even taking any medication for her hypertension, and her last reading in [redacted] was within normal range.

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 re-apply at any time should her medical conditions change.

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: 11/29/2010

***** 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.