STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant

_____/

Docket No. 2011-15306 QHP
Case No. 17113841

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 who was present and testified. [redacted], [redacted], represented the health plan, [redacted]. Her witnesses were [redacted], and [redacted].

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for bariatric surgery?

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's Exhibit #1)

2. The Appellant is [redacted] who weighs 237 pounds and has a BMI of 42.0. (See Respondent's Exhibit A, p. 12)

3. On or about [redacted], the MHP received the Appellant's request for prior approval (PA) of Bariatric surgery from the Appellant's primary care physician, [redacted] and prospective surgeon, [redacted], [redacted]. (Respondent Exhibit A, pp. 37-41)

4. The Appellant's request was medically reviewed, denied and internally appealed and denied again. The Appellant then sought an administrative hearing before the Michigan Administrative Hearing System. (See

Respondent's Exhibit A, pp. 37-59)

5. The Appellant is afflicted with obesity, arthritis, cervical, dorsal and lumbar somatic dysfunction, muscle spasm, myalgia, recurrent hip pain, GERD, hyperlipidemia, constipation, hypokalemia, depression and insomnia, sleep apnea, SOB and recurrent joint pain. (Respondent's Exhibit A, p. 17 and See Testimony)

6. The MHP [redacted] reviewed the case and testified that she was denied for lack of compliance with MHP policy on weight loss regimen for a minimum of one year. (See Testimony and Respondent's Exhibit A, p. 61)

7. The MHP provided ample evidence that the Appellant had non-complying participation throughout her partial participation in Medical Weight Loss program [40 weeks] program indicating a lack of commitment to the dietary program thus foretelling a lack of success post surgery. (See Testimony)

8. On [redacted], the Appellant was advised of the denial for PA of bariatric surgery. Her further appeal rights were contained therein. (Respondent Exhibit A, pp. 38, 39)

9. The instant request for hearing was received by the Michigan Administrative Hearing System 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 MHP witnesses testified that the Appellant had, over the course of a year, failed to comply with the terms and conditions of the HPM policy for authorization of Bariatric Surgery. [redacted] testified that chief among his concerns was the Appellant's failure to complete her 52-week weight loss program – which they still supported that their member revisit as of the date of hearing.

The Appellant testified that she was concerned over the large number of medications she is taking [over 20]. She opined that with weight loss – the amount she envisions through surgery – that she would be able to become more active and "start doing things."

See also, Respondent's Exhibit A, pp. 10-11

The MHP and their exhibit showed that there was no realistic evidence to demonstrate a commitment to a dietary change – post surgery. The ALJ found the Appellant's psychological assessment for post surgical commitment to be guarded. It was not a strong endorsement for post surgical success with weight loss and the difficulties a patient would confront post procedure. *See* Respondent's Exhibit A, pp. 25-29.

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, April 1, 2011, page 40.

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The Petitioner has the burden of proving by a preponderance of evidence that she met the Medicaid policy criteria for coverage of Bariatric surgery. The MHP witness testified that they considered the medical documentation, in accordance with Medicaid policy and their own policy for Bariatric Surgery. The MPH established that Appellant had not demonstrated the medically necessary program compliance to justify the risk of Bariatric surgery.

The MHP properly denied the request for Bariatric 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 for Bariatric surgery.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Dale Malewska
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4/26/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.