STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted],

Appellant

Docket No. 2011-54872 QHP
Case No. [redacted]

/

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], the Appellant, appeared on her own behalf. [redacted], Grievance Coordinator, represented [redacted], the Medicaid Health Plan (hereinafter MHP). [redacted], Executive Medical Director, and [redacted], Clinical and Quality Review Specialist, appeared as witnesses 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], a Medicaid Health Plan (MHP).

2. On [redacted], the MHP received a request for a medical evaluation for bariatric surgery for the Appellant. The request indicates that the Appellant has co-morbidities of hypertension, diabetes mellitus, and hyperlipidemia. Additional medical documentation was attached. (Exhibit 1, pages 6-18)

3. Michigan Department of Community Health, Medicaid Provider Manual

Policy regarding weight reduction only allows for coverage of obesity treatment when done for the purposes of controlling life-endangering complications, such as hypertension and diabetes. Medicaid does not cover treatment specifically for obesity or weight reduction and maintenance alone. *Department of Community Health, Medicaid Provider Manual, Practitioner, 4.22 Weight Reduction, Version Date: July 1, 2011, Page 39.*

4. On [redacted], the MHP sent the Appellant a denial notice stating that the request for an evaluation for bariatric surgery was not authorized, referencing the Medicaid Provider Manual policy. The letter noted that the records from the Appellant's doctor say she has high blood sugar, high blood pressure, and a high fat count in her blood. Problems that may be life endangering are high blood sugar and high blood pressure not controlled by medication. The records show the Appellant is on medication for high blood sugar and high fat count, but not high blood pressure. Therefore, the Appellant's request was not approved. (Exhibit 1, pages 19-21)

5. On [redacted], the Appellant requested a formal, administrative hearing contesting the denial. (Exhibit 1, page 22)

6. The MHP also conducted an internal grievance procedure upon receipt of the Appellant's request for hearing. On [redacted], a hearing with the MHP's Grievance Committee occurred and the Appellant provided additional medical records. (Exhibit 1, pages 2 and 27-35)

7. On [redacted], the MHP sent the Appellant a letter indicating the Grievance Committee denied the Appellant's request for bariatric surgery coverage. (Exhibit 1, pages 36-38)

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: July 1, 2011, Page 39.

The Executive Medical Director testified that in this case, the MHP followed the Medicaid Provider Manual criteria, which indicates that bariatric surgery is not covered unless it is to treat life threatening co-morbidities. The Executive Medical Director explained that the medical records showed the Appellant's main health problems are diabetes and obesity, and there is excellent control of the Appellant's diabetes. Accordingly, the Appellant's diabetes is not a life threatening co-morbidity and bariatric

surgery is not a covered service. (Executive Medical Director Testimony)

The Appellant disagrees with the denial and testified that she also has osteoarthritis of her hips. The Appellant submitted additional documentation to the MHP during the internal grievance proceedings regarding her hips. (Appellant Testimony and Exhibit 1, pages 27-35) The Executive Medical Director testified that bariatric surgery would not fix damage to bone. He further stated that hypothetically osteoarthritis would have a slower progression of bone changes with a normal body weight. However, even persons with a normal BMI end up having to have hip replacement. (Executive medical Director Testimony)

The MHP considered the Appellant's bariatric surgery request under the Medicaid Provider Manual criteria. The Appellant's medical records do not show any uncontrolled life threatening complications. (Exhibit 1, pages 8-18 and 27-35) Based on the submitted information, the Appellant does not meet criteria for approval of bariatric surgery. The MHP's determination is upheld.

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 Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 12/16/2011

***** 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.