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]

Docket No. 2012-26410 QHP

[redacted] [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.,* upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant appeared without representation. She had no witnesses. [redacted] Hearings Coordinator, represented the Medicaid Health Plan (MHP). Her witness was Chief Medical Officer, [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]. Appellant's Exhibit #1.

2. The Appellant is a [redacted]-year-old female who weighs [redacted] Respondent's Exhibit A, p. 1.

3. The Appellant is afflicted with HTN, apnea and GERD. Her physician, in a [redacted] communication, observed that given her 50+ BMI and failure to respond to phentermine[sic], exercise and diet that the Appellant was a suitable candidate for Bariatric surgery. Respondent's Exhibit A, p.21.

4. On or about [redacted] the MHP received and denied the Appellant's request for coverage of proposed Bariatric surgery. Respondent's Exhibit A, pp. 1-3.

5. On [redacted] the Appellant requested an internal appeal with [redacted] Appeals Review Committee [which included a general surgeon]. The review committee denied the Appellant's request for lack of evidence of any consistent weight loss. Respondent's Exhibit A, p. 1

6. On [redacted], the Appellant was advised, in writing, that her request was denied. She was given instructions for further appeal. Respondent's Exhibit A, p. 2.

7. The MHP Medical Director, [redacted], observed that the Appellant failed to meet program criteria – specifically her lack of attendance [for one year] at a physician supervised weight loss program, which included a weight loss diet, exercise and behavior modification within the last [redacted] years, with regular attendance showing ongoing weight loss – medically supervised by a plan provider. Respondent's Exhibit A, pp. 2 and 3.

8. 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.

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The MHP witnesses [redacted] testified that the Appellant failed to meet [redacted] requirements as a plan member with a life threatening complication such as HTN, DM or other illness that would be otherwise unresponsive to treatment – thus requiring bariatric surgery. They added that the Appellant's request lacked documentation of participation in a weight loss program and that the only information received from her submitting physician was a one page summary of events.

[redacted] added that the Appellant Review Committee found that the Appellant had actually gained weight prior to her request for Bariatric surgery and thus failed to meet the criteria for such surgery on internal review. *See* Respondent's Exhibit A, pp. 6 – 8.

The Appellant said that her weight loss was inconsistent for the last [redacted] and that was why she needed the surgery. She said she was concerned about the health issues of HTN and apnea.

[redacted] acknowledged that excess weight can aggravate apnea and HTN – but that the Appellant's circumstance was not life threatening. The MHP and their exhibit showed that there was no evidence to demonstrate a life threatening condition in the Appellant or that she met the criteria for Bariatric surgery. *See* Respondent's Exhibit A, throughout.

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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, 2012, page 38.

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The Appellant has the burden of proving by a preponderance of evidence that she met the Medicaid policy criteria for coverage of Bariatric surgery. The MHP witnesses testified that they considered her medical documentation and testimony at their internal grievance hearing and found it lacking. The MHP established today that Appellant had not demonstrated the existence of life threatening medical conditions or adequate participation with a medically supervised weight loss program sufficient 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.

[redacted].
Docket No. 2012-26410 QHP
Decision and Order

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: 4-20-12

***** 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.