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:

Docket No. 2012-50902 PA

[redacted] Case No. [redacted]

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9; MSA 16.409 and MCL 400.37; MSA 16.437 upon t he Appellant's request for a hearing appealing the Department's decision to deny Appellant's request for prior authorization of gastric bypass surgery.

After due notice, a hearing was held [redacted] The Appell ant appeared without representation. She had no witnesses. [redacted]. Her [redacted]

ISSUE

Did the Department properly deny Appellant's request for laparoscopic sleeve gastrectomy 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. The Appellant is a fee for service Medicaid beneficiary.

2. The Appellant seeks prior authorization for sleeve gastrectomy surgery.

3. The Appellant is a [redacted] She has no known uncontrolled, life threatening co-morbidities. (Department's Exhibit A)

4. The Appellant has survived breast cancer and has undergone a double masectomy.

5. The Appellant has attempted to have br east reconstructive surgery on more than

one occasion. The reconstructive surgery has not been successful.

6. The Appellant's surgeon attributes the lack of success in breast reconstructive surgery to the Appellant's body habitus.

7. The Appellant's surgeon indicates her risk of recurrent breast cancer is higher because of her obesity.

8. On [redacted], the [redacted] prior authorization division received a P.A. request from [redacted] seeking prior authorization for sleeve gastrectomy surgery for the Appellant. (Department's Exhibit A)

9. The Department's [redacted], reviewed the request for prior authorization and medical documentation submitted in conjunction with the request.

10. The Department's reviewer determined thatthe Appellant did not have uncontrolled, life threatening co-morbidities. Additionally, she had not submitted any documentation indicating she had participated in a physician supervised weight reduction program. (Department A)

11. On [redacted] the Appellant was advised that the PA surgical request was denied. (Department's Exhibit A)

12. On [redacted] the instant request for hearing was received by the [redacted] for the [redacted]

CONCLUSIONS OF LAW

The Medical Assistance Program isestablished pursuant to TitleXIX 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.

The Medicaid covered benefits are addressed for the practitioners and beneficiaries in the Medicaid Provider manual. The relevant portion for the issue in this case is set forth below.

1.10 PRIOR AUTHORIZATION

Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility. Different types of services requiring PA include:

- Procedures identified as requiring PA on the procedure code databases on the MDCH website;
- Procedures/items that are normally non-covered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery, off-label use drugs, etc.); and
- Referrals for elective services by out-of-state non-enrolled providers.

1.10.A. TO OBTAIN PRIOR AUTHORIZATION

Providers must submit a letter to the MDCH Program Review Division to obtain PA.
(Refer to the Directory Appendix for contact information.) The letter and materials submitted requesting PA must include:

- Beneficiary's name and Medicaid ID number.
- Provider's name, address, NPI number.
- Contact person and phone number.
- A complete description, including Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) procedure codes as appropriate, of the procedure(s) that will be performed.
- The beneficiary's past medical history, including other treatments/procedures that have been tried and the outcome, diagnostic test results/reports, expectations and prognosis for the proposed procedure, and any other information to support the medical need for the service.

Providers receive a written response from MDCH. If the authorization is granted, the provider receives a PA number to report on the claim. The physician obtaining PA must make the PA number available to other providers, such as other practitioners or the hospital, for billing purposes.

If the beneficiary has Medicare and Medicare covers the service, the provider does not have to obtain PA from Medicaid. If Medicare denies a service as not medically necessary, Medicaid does not cover the service even if a PA has been obtained. If Medicare identifies a service as an excluded benefit under Medicare and Medicaid requires PA, the provider must pursue PA from Medicaid and a coverage determination is made. If the beneficiary has commercial insurance that covers the service and the provider reports the coverage correctly on the claim, the provider does not have to obtain PA from Medicaid. If a primary insurer covers a service but requires PA and the provider

does not follow the primary insurance PA process, Medicaid does not make payment for the service either.

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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.

Medicaid Provider Manual (MPM) Practitioner, §4.22,
January 1, 2012, p. 4-5 and 38

In this case the Department had a physician review the request for prior authorization and accompanying documentation. She determined there was no medical documentation indicating the Appellant has uncontrolled, life threatening co-morbidities. She further determined the Appellant had not submitted any documentation to show she had participated in a physician supervised weight loss program or other serious conservative treatment for weight loss that had failed. The Department reviewer saw the Appellant has a history of breast cancer, double mascectomy and chemotherapy. She saw the Appellant had failed in her attempt to have breast reconstruction surgery and that her surgeon attributed this to her body habitus. She also saw the Appellant's physician's opinion that her obesity elevates the risk of recurrence of breast cancer. After considering the Appellant's specific medical condition, history and circumstances, she determined the Appellant had not established the gastric sleeve surgery was medically necessary. She testified to this at hearing. She stated that based upon the medical documentation

provided, that the Appellant was not suffering any life threatening co-morbidities that the surgery sought would address. Additionally, weight reduction surgery to address the risk of recurrence of the specific type of breast cancer the Appellant had is not the current medical standard of care.

The Appellant's testimony asserted is that she has struggled with attempts at weight loss for years. She had been on a physician supervised weight loss years ago, had lost 30 or 40 pounds and gained it back after discontinuing the medication she had been given to assist. She stated she has also addressed issues of over eating in counseling. She said her doctor thinks she should have this surgery as well, despite not having been in favor of it initially.

After reviewing the evidence of record, this ALJ must uphold the Department reviewer's determination. There was no evidence to refute the Department's determination that the Appellant is not experiencing an uncontrolled, life threatening co-morbidity. This ALJ is certainly sympathetic to the Appellant's circumstance and position, however, has no equitable jurisdiction. The Department has applied its policy to the Appellant's specific circumstances and made it's determination based upon the current medical practices and standards of care. This ALJ is without authority to alter the Department policy concerning weight reduction surgery.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for gastric bypass surgery.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Signed: _____

Date Mailed: _____

***** 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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.