



4. The medically supervised weight loss documentation submitted shows a beginning weight of █████ pounds on █████ and a final weight of █████ pounds on █████.
5. On September █████, the MHP sent the Appellant a denial notice stating that the request for bariatric surgery was not authorized because the submitted documentation did not show regular attendance and ongoing weight loss with a physician supervised weight loss program that included a weight loss diet, exercise, and behavior changes for at least one year and done within the last two years.
6. On December █████, the Appellant requested a formal, administrative hearing contesting the denial.

### **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: April 1, 2011, Page 40.*

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP Medical Director explained that for a procedure such as bariatric surgery, the MHP reviews prior approval requests under the [REDACTED] Utilization Guideline for Bariatric Surgery. (Exhibit 1, pages 6-8) The Utilization Guideline for Bariatric Surgery includes a requirement for:

4. Physician documented successful participation in a physician supervised weight loss program involving a weight loss diet, exercise, and behavioral modification for a minimum of one (1) year, performed within the last two (2) years. Successful participation is determined at a minimum by documented regular attendance (at least monthly) and demonstration of consistent weight loss. The weight loss program must be medically supervised and provided by a plan provider. A physician's summary letter will not be considered sufficient documentation. The documentation must include medical records/clinical notes of the physician's contemporaneous assessment of the member's progress throughout the course of the weight loss program. (Exhibit 1, page 6)

The Medical Director explained that the documentation submitted with the Appellant's prior authorization request demonstrated the Appellant was not successful in the medically supervised weight loss program she participated in. He explained part of the criteria is success in weight loss and that is explicitly stated in the written criteria.

The Appellant disagrees with the denial and testified that she was never told she had to actually lose weight. She stated she was told she had to participate in the program for a year and she did. She further testified she exercised and has done everything she is supposed to have done. She protested that the MHP "holds all the cards" and they should be made to reveal what the criteria actually says so the participants have a chance of meeting it.

The MHP Medical Director testified that the criteria is provided to the doctors and they rely on

the doctors to inform the patients of the medical requirements.

Under its contract with the Department, an MHP may devise criterion for coverage of medically necessary services, as long as those criteria do not effectively avoid providing medically necessary services. 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 criteria for approval of bariatric surgery. The submitted documentation does not show at least 12 months of continuous successful participation in a physician supervised weight loss program within two years prior to the request.

The Appellant did not meet the MHP's physician supervised weight loss program criteria for bariatric surgery based on the documentation submitted with the prior authorization request. 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.

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

cc: [REDACTED]

Date Mailed: 3-5-12

**\*\*\* 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.