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) 373-4147

IN THE MATTER OF:

Docket No. 2013-13973 QHP
Case No.

Appellant
_____________________/

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 . , the Appellant, appeared on her own behalf. , Grievance Coordinator, appeared and testified on behalf of Physicians Health Plan of Mid Michigan Family Care, the Medicaid Health Plan (hereinafter MHP). , R.N., Customer Services, also appeared as a witness for the MHP.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for an evaluation 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 -year-old female Medicaid beneficiary who is currently enrolled in Physicians Health Plan of Mid-Michigan Family Care, a Medicaid Health Plan (MHP).

2. On , the MHP received a request from requesting coverage for a medical evaluation for for the Appellant. The request indicates that the Appellant has hypertension, and was previously treated for a pre-diabetic condition. (Exhibit A, pp. 2, 6-57 and Testimony).

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, [redacted], Page 38.*

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 stated the Appellant's request was not approved, because Medicaid only covers treatment of obesity for the purpose of controlling life endangering complications such as hypertension and diabetes. The information provided by [redacted] did not establish that the Appellant had any such conditions. (Exhibit A, pp. 58-60).

5. On [redacted], MAHS received a Request for Hearing from the Appellant stating she has hypertension and has been taking [redacted]r for it for 3 years, and she also is borderline diabetic. (Exhibit A, p. 61).

6. On [redacted], Appellant sent the MPH a written request for coverage for the bariatric surgery evaluation which initiated the internal grievance process with the MPH. On [redacted], the MPH sent another letter advising Appellant that the requested coverage was denied because it did not meet the coverage criteria under the Medicaid Provider Manual. The letter invited Appellant to attend a grievance hearing on [redacted]. (Exhibit A, pp. 62-66).

7. On [redacted], a grievance hearing with the MPH was held and the Appellant attended and testified at the hearing. Appellant also provided additional medical records at the hearing. On [redacted], the MPH sent Appellant another letter advising that the requested coverage was denied because it did not meet the coverage criteria under the Medicaid Provider Manual. (Exhibit A, pp. 67-76).

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 [redacted] 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.
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> *Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans,* .
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> The major components of the Contractor's utilization management plan must encompass, at a minimum, the following:
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> - 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, .

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,
, Page 38.

The Grievance Coordinator testified that in this case, the MHP followed the Medicaid Provider Manual criteria, which indicates that an evaluation for bariatric surgery is not covered unless it is to treat life threatening co-morbidities. The Grievance Coordinator explained that the Appellant's medical records did not show that the Appellant had

uncontrolled life threatening conditions such as hypertension or diabetes. The MPH's Nurse in Customer Services stated that she has been a registered nurse for years. The Nurse reviewed Appellant's medical records back to She stated that the Appellant is on medications for high blood pressure which is keeping her blood pressure within normal limits. The Nurse also noted that the Appellant had a pre-diabetic condition and was given medication for that condition, (but no longer takes that medication. The Nurse stated that a review of the Appellant's medical records for and do not show that the Appellant's blood sugar has been uncontrolled during that period of time. The Nurse concluded that based upon the relevant policy in the Medicaid Provider Manual, the Appellant was not eligible for the evaluation for because she does not have uncontrolled life threatening conditions.

The Appellant testified that she believes she understands the guidelines for the requested services. She acknowledged that she went off when she became pregnant, and was then put on She further stated that she is no longer taking to control her blood sugar. Appellant also acknowledged that her hypertension was controlled with her Appellant indicated she has a BMI of 58.8, she has a hard time getting around, and has she has to care for. She wants to have the to improve her life and her life.

The Appellant stated that she believed that her high BMI qualified her for the The MPH's Nurse responded, however, that Medicaid covers treatment of obesity only when done for the purpose of controlling life-endangering complications, such as hypertension and diabetes. Since the Appellant did not have such conditions the evaluation for bariatric surgery could not be approved.

The MHP considered the Appellant's request for an evaluation for bariatric surgery under the Medicaid Provider Manual criteria. The Appellant's medical records do not show any uncontrolled life threatening complications. (Exhibit A, pp. 6-57, 67-70). Based on the submitted information, the Appellant does not meet criteria for approval of an evaluation for 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 an evaluation for bariatric surgery.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is **AFFIRMED**.

/s/
William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc:

Date Mailed: February 7, 2013

***** 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.