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. 2013-14060 QHP
Billings, Ezeltta, **Case No.** 88333569

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 Thursday February 7, 2013. The Appellant appeared without representation. She had no witnesses. The Respondent health plan was represented by Appeals Coordinator, Alexandria Ziegler. Her witness was Medical Director, Dr. Keith Tarter, MD.

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 is enrolled in Molina Health Plan. (Appellant's Exhibit #1)

2. The Appellant is a 36-year-old female who weighs 365 pounds, with a BMI of 60.7 (Respondent's Exhibit A, pp. 1 and 10)

3. The Appellant is afflicted with morbid obesity, HTN, DM II and chronic low back pain. (*See* Testimony and Respondent's Exhibit A , p. 1)

4. On or about October 17, 2012, the MHP received the Appellant's request for coverage of laparoscopic gastric bypass surgery. (Respondent's Exhibit A, pp. 1 and 5 through 59)

5. On October 31, 2012, the Appellant was advised, in writing, that her

request was denied. She was given instructions for further appeal. (Respondent's Exhibit A, pp. 60-63)

6. The MHP Medical Director, Dr. Tarter, MD, observed that the Appellant failed to meet program criteria – most notably that she gained weight during the required one year of medically supervised weight loss program, thus demonstrating a failure of attaining consistent weight loss. (*See* Testimony of Tarter and Respondent's Exhibit A, pp. 1 and 60)

7. The instant request for hearing was received by the Michigan Administrative Hearing System on November 16, 2012. (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 [Ziegler and Tarter] testified that the Appellant failed to meet plan requirements and utilization guidelines demonstrating that the member had successful participation in a physican supervised weight loss program that included a weight loss diet, exercise and behavior changes for at least one year – accomplished within the last 2 years.

Dr. Tarter noted that successful participation was determined with documentation of regular attendance, which he observed the Appellant to have achieved with a similar demonstration of consistent weight loss – which she did not evidence.

A review of the record showed that the Appellant had satisfied all other utilization requirements. [*See* Respondent's Exhibit A, pp. 5 – 59]

The Appellant said that she requires the frequent administration of a "diuretic" and that owing to her fluid retention her weight goes "straight up." She added that she understood both the medical risk and policy but opined that "…this was a matter of life and death and that [she] should not be denied…"

The MHP witnesses and their exhibit showed that there was no evidence to demonstrate consistent weight loss in the Appellant for one year. [*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,[1] January 1, 2013, page 39.

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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 laparoscopic gastric bypass surgery. The MHP witness testified that they considered her comprehensive medical documentation and found it lacking any evidence of consistent weight loss for a period of one year within a 2 year period.

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.

IT IS THEREFORE ORDERED that:

[1] The edition of the MPM is Identical to the version in place at the time of the October 2012 authorization request.

The Medicaid Health Plan's decision is AFFIRMED.

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Dale Malewska
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: Ezeltta Billings
Camille Adams
Jeanette Robinson

Date Mailed: 2/11/2013

*** **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.