

**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. 2013-45715 QHP

██████████  
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 on ██████████ ██████████ the Appellant, appeared on her own behalf. ██████████ Paralegal, represented ██████████ ██████████ the Medicaid Health Plan (MHP). ██████████ Medical Director, appeared as a witness for the MHP.

**ISSUE**

Did the MHP properly deny the Appellant's prior authorization request 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 Medicaid beneficiary who is currently enrolled in the Respondent MHP, UnitedHealthcare Community Plan.
2. On or about ██████████ the MHP received a prior authorization request for surgery for removal of lap band/port and conversion to gastric sleeve for the Appellant. The available information indicated the Appellant had been experiencing left-sided abdominal pain recently. The pain started after her partial nephrectomy. A ██████████ letter from the Appellant's doctor, in part, states an esophagram was ordered and was reportedly normal. The ██████████ esophagogastroduodenoscopy report did not show any problems with the lap band. (Exhibit C)
3. On ██████████, the MHP sent the Appellant notice that the request for to change her current weight reduction procedure to a sleeve gastrectomy was denied because the rules only allow for one bariatric procedure per

lifetime unless there is a medical problem that requires a life threatening problem to be fixed. Further, the Appellant would be required to go thru a process and meet certain rules to get any bariatric surgery and the MHP could not see that the Appellant had met any rules. (Exhibit A)

4. On ██████████ the Appellant's Request for Hearing was received by the Michigan Administrative Hearing System.

### **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 MHPs.

The Respondent is one of those MHPs.

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/EPSTD for persons under age 21

Article 1.020 Scope of [Services],  
at §1.022 E (1) contract, 2010, p. 22.

- (1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:
  - (a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
  - (b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.
  - (c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.
  - (d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.
  - (e) The UM activities of the Contractor must be integrated with the Contractor's QAPI program.
- (2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages 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 UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

....

Contract, *Supra*, p. 49

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:

**4.21WEIGHT REDUCTION [RE-NUMBERED 4/1/13]**

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, 2013, Page 38.*

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviewed the prior approval request under the MAHP Bariatric Surgery Guidelines for Coverage. (Exhibit B) The MAHP Bariatric Surgery Guidelines for Coverage states:

**Description:**

Surgery for morbid obesity is an alternative to traditional weight loss methods when such methods have failed to yield sufficient weight loss in Members who are at great risk of complication due to their obesity.

**Criteria:**

Members may receive surgical intervention for obesity when the following criteria are met:

1. Must be at least 18 years of age
2. BMI  $\geq$ 35 and two co-morbidities.

Co-Morbidities include but not limited to:

- Poorly controlled diabetes mellitus.
- Symptomatic sleep apnea not controlled by C-Pap.
- Severe cardio-pulmonary condition
- Hypertension inadequately controlled with optimal conventional treatment
- Uncontrolled Hyperlipidemia not amenable to optimal conventional treatment

3. BMI  $\geq$  40 with or without co-morbid conditions.
4. Prior authorization by the Medical Director based on the following criteria and subject to providers as authorized by Plan.
5. **Documented compliance with a weight loss program including diet, exercise, and behavioral modification for a minimum of one year.**

*The weight loss program must be medically supervised and provided by a plan provider and available and accessible to members. Members will be covered for all medical services but not for food supplements. All medical services related to the program including laboratory, EKGs, physician office visits, psychological testing will be covered with applicable co-payments and/or deductibles required under the certificate. The facility must utilize a multidisciplinary approach, including but not limited to: involvement of a physician which a special interest in obesity, a dietitian, a social worker (MSW), psychologist or psychiatrist interested in behavior modification and eating disorders. Plans should have pre and post surgical support both available and accessible with coverage clearly stated to its members.*

6. A psychological evaluation must be performed prior to surgery in order to establish the member's emotional stability and ability to comply with post-surgical limitations.
7. Requires referral by primary care physician to a multidisciplinary team.
8. **The member must receive treatment at a facility utilizing a multidisciplinary approach, involving a physician with a special interest in obesity, a dietician, a psychologist or psychiatrist interested in behavior modification and eating disorders, and a surgeon with experience in all aspects of bariatric procedures.**
9. Long term behavioral modification support and lifelong medical surveillance after surgical therapy is a necessity.
10. Member has undergone medical evaluation to rule out other treatable causes of morbid obesity.
11. A member shall only have one bariatric surgical procedure per lifetime unless medically necessary complication to correct or reverse a previous bariatric procedure from complications. (Underline added by ALJ)

Exhibit B

The MHP denied the prior authorization request because the Appellant has already had one bariatric procedure, a lap band, and the submitted documentation did not show a medical problem that requires a life threatening condition to be fixed. The Medical Director testified that the pain the Appellant is experiencing is more likely due to post-operative adhesions from the kidney surgery. The weight gain is also likely from inactivity during the Appellant's recovery period after the kidney surgery. Further, the submitted documentation did not show a plan has been tried regarding the recent weight gain. (Hearing Summary; Exhibit A; Exhibit C; Medical Director Testimony)

The Appellant disagrees with the denial and testified that she had the lap band surgery in ████████. The Appellant had lost over ██████ pounds with the lap band, but quickly gained back ██████ pounds since the kidney surgery. The Appellant acknowledged that she did a lot of sitting in the ██████ months after her ██████████ kidney surgery. The Appellant stated that the pain started after the kidney surgery but is in the lap band and

port area. The Appellant is worried for herself, including that other functioning organs will break down or if she were to become a diabetic now that she only has one kidney. The Appellant stated her doctors feel the sleeve would be a good thing for her. The Appellant is in a lot of pain. (Appellant Testimony)

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 documentation, the Appellant did not meet criteria for approval of surgery for removal of lap band/port and conversion to gastric sleeve. The Appellant has had once bariatric procedure in her lifetime, and the submitted documentation did not establish it is medically necessary to correct or reverse the previous bariatric procedure from complications. The [REDACTED] letter from the Appellant's doctor stated an esophagram was ordered and it was reportedly normal. The doctor further stated that if the Appellant's pain continued they would proceed with a CT scan of the abdomen and pelvis. Further, the [REDACTED] esophagogastroduodenoscopy report did not show any problems with the lap band. The MHP's determination is upheld based on the available information.

### **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.

/s/

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Colleen Lack  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

CL/db

cc: [REDACTED]

[REDACTED]  
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**\*\*\* 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.