

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:

██████████,

Appellant

_____ /

Docket No. 2013-66202 QHP

██████████

██████████

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.*, and upon the Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant appeared and testified on her own behalf. ██████████, Paralegal, represented ██████████, the Medicaid Health Plan (██████████). ██████████ Medical Director, appeared as a witness for the ██████████.

ISSUE

Did the ██████████ 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. Appellant is a ██████████ year-old Medicaid beneficiary who is currently enrolled in the Respondent ██████████ (Respondent's Exhibit C, page 2).
2. Appellant has been diagnosed with stomal dilation and morbid obesity. (Respondent's Exhibit C, page 5).
3. On ██████████, Appellant underwent laparoscopic gastric bypass surgery through the ██████████. (Respondent's Exhibit C, pages 17-18).
4. On or about ██████████, the ██████████ received a prior authorization request from Appellant's doctor for Gastric Outlet Repair surgery for Appellant. (Respondent's Exhibit C, pages 1-19).

5. The Pre-Certification attached to that request indicated that, while Appellant lost over █████ pounds following her earlier surgery, she has begun to regain weight and her doctor wanted to perform an endoscopic repair of Appellant's enlarged gastrojejunal anastomosis. (Respondent's Exhibit C, page 3).
6. The doctor's letter also indicated that Appellant is suffering unnecessarily from weight gain and depression, and that the surgery would offer her a much better quality of life. (Respondent's Exhibit A, page 4).
7. On █████, the █████ sent the Appellant written notice that the prior authorization request was being denied. (Respondent's Exhibit A, page 1).
8. Specifically, the denial stated:

Based on review of the information provided the following determination has been made:

You asked for surgery to help your prior bariatric surgery work better. You have stopped losing weight. We looked at the █████ rules for this. We did not see that you had a medically significant problem that needs to be fixed. Our rules were not met. Your request is denied.

Respondent's Exhibit A, page 1

9. On █████, the Michigan Administrative Hearing System (MAHS) received a Request for Hearing filed by Appellant with respect to the denial of her prior authorization request. (Petitioner's Exhibit 1, pages 1-4).

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 Michigan Department of Community Health 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 ██████████ and is responsible for providing covered services pursuant to its contract with the Department:

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 . . .

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

As stated in the Department-██████████ contract language above, a ██████████ 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:

4.21 WEIGHT 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. . .

*MPM, July 1, 2013 version
Practitioner Chapter, page 40*

The DCH-██████████ contract provisions also allow for prior approval procedures for utilization management purposes.

- (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 . . .

Contract, *Supra*, p. 49

In this case, the ██████ reviewed the prior approval request under the MAHP Bariatric Surgery Guidelines for Coverage. (Respondent's 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 dietitian, 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.

*Respondent's Exhibit B
(Underline added by ALJ)*

Pursuant to the above guidelines, the ██████ denied the prior authorization request because the Appellant has already had one bariatric procedure and the submitted documentation did not show a medical complication or problem arising from that procedure that needed to be corrected or reversed.

Appellant bears the burden of proving by a preponderance of the evidence that the ██████ erred in denying her prior authorization request. In this case, given the above policy and the evidence found in the record, Appellant has failed to meet that burden of proof and the ██████ decision must be sustained.

Appellant's doctor stated that he was requesting an endoscopic repair of Appellant's enlarged gastrojejunal anastomosis because Appellant had begun to regain weight and was suffering unnecessarily from weight gain and depression. Appellant also points to an ██████ procedure that revealed a large size pouch in her stomach. According to Appellant, that enlarged pouch is a result of the previous bariatric procedure and needs to be corrected so that she can continue to lost weight.

Even though it is undisputed that the pouch is a result of the previous procedure, Respondent's witness, ██████, testified that there is no health risk posed by the pouch/enlarged gastrojejunal anastomosis and it is not a complication that needs to be addressed. Similarly, Appellant's doctor fails to identify any health risk justifying the requested surgery and, instead, merely asserts that Appellant's attempts at weight loss could improve with a second surgery.

However, the mere fact that Appellant's first surgery was not as successful as she hoped, does not justify a second surgery. Under its contract with the Department, an ██████ may devise criterion for coverage of medically necessary services, as long as those criteria do not effectively avoid providing medically necessary services. As described above, the criterion in this case provides that 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.

The ██████ bariatric surgery prior approval process is consistent with Medicaid policy and allowable under the DCH-██████ contract provisions. The ██████ also demonstrated that Appellant did not meet criteria for approval of surgery for gastric outlet repair in this case as Appellant has already had a bariatric procedure in her lifetime and the submitted documentation did not establish it is medically necessary to correct or reverse complications from the previous bariatric procedure. Accordingly, the ██████ decision must be sustained.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the ██████ properly denied the Appellant's prior authorization request for bariatric surgery.

[REDACTED]
Docket No. 2013-66202 QHP
Decision and Order

IT IS THEREFORE ORDERED that:

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

Steven Kibit

Steven Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

SK/db

cc: [REDACTED]

***** 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.