

**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. 14-005539 MHP  
Case No. ██████████

**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. ██████████, appeared and testified on behalf of ██████████, the Medicaid Health Plan (hereinafter MHP). ██████████, Medical Director, also appeared as a witness for the MHP.

**ISSUE**

Did the MHP properly deny Appellant's 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 ██████-year-old female Medicaid beneficiary who is currently enrolled in the MHP.
2. From approximately ██████████ through ██████████ the Appellant actively participated in the ██████████. During the past year, the Appellant lost 1 pound. (Exhibit A, p. 3; Testimony)
3. On or around ██████████, the Appellant's treating physician submitted to the MHP a prior authorization request for a lap sleeve gastrectomy (bariatric procedure). The prior authorization request included numerous medical records. The medical records indicated the Appellant had lost 1 pound in the previous year. (Exhibit A, pp. 8-118)
4. On ██████████, the MHP sent the Appellant a denial notice stating that the request the lap sleeve gastrectomy was being denied. The letter

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stated the Appellant's request was not approved, as the Appellant had not had a successful participation in a physician supervised weight loss program for at least one year. (Exhibit A, pp. 119, 120)

5. On [REDACTED], MAHS received a Request for Hearing from the Appellant. (Exhibit A, p. 2).

**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

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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:

**4.21 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

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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, October 1, 2013 version  
Practitioner Chapter, page 41*

Moreover, pursuant to its authority to limit services to those that are medically necessary based on its own prior authorization requirements, utilization management or review criteria, the MHP also reviews prior approval requests for bariatric surgeries under the MHP's Bariatric Surgery Guidelines (Respondent's Exhibit A, pp. 5, 6). These guidelines contain certain criteria for authorizing surgical intervention for obesity and are consistent with the Medicaid standard of coverage to only prior authorize medically necessary treatment of obesity when done for the purpose of controlling life-endangering complications, do not effectively avoid providing medically necessary services, and are allowable under the DCH-MHP contract provisions.

Appellant bears the burden of proving by a preponderance of the evidence that the MHP erred in denying her request for bariatric surgery.

Here, based on the evidence presented in this case, the MHP properly denied Appellant's request for bariatric surgery based on MPM and the MHP Guidelines.

The evidence and documentation submitted in this case provide that, while Appellant is overweight and has co-morbidities, she has no uncontrolled, life-endangering complications arising from her obesity.

As such, the denial was proper. Medicaid does not cover treatment specifically for obesity or weight reduction and maintenance alone and that is all Appellant's documentation identified in this case.

The MHP's bariatric surgery prior approval process is consistent with Medicaid policy and allowable under the DCH-MHP contract provisions. Here, the MHP demonstrated that the Appellant did not meet criteria for approval of bariatric surgery based on the information available at the time of this request and its decision must be affirmed.

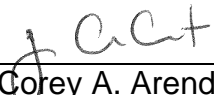
[REDACTED]  
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**DECISION AND ORDER**

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

**IT IS THEREFORE ORDERED** that:

The MHP's decision is **AFFIRMED**.

  
\_\_\_\_\_  
Corey A. Arendt  
Administrative Law Judge  
for James K. Haveman, Director  
Michigan Department of Community Health

CAA [REDACTED]

cc: [REDACTED]

Date Signed: [REDACTED]

Date Mailed: [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.