**STATE OF MICHIGAN**
**MICHIGAN ADMINISTRATIVE HEARING SYSTEM**
**FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

**IN THE MATTER OF**:

**Docket No.** 15-015047 MHP

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. , Quality Management Administrator, appeared and testified on behalf of , the Medicaid Health Plan (MHP). Manager of Medical Management, 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. The Appellant tracked her diet and exercise from approximately through as part of her supervised weight loss program. The exercise and food journals did not include daily calorie counts and included food selections ranging from soda, pizza, doughnuts, bologna, French fries, cheeseburgers, popsicles, cake, ice cream etc. The food journals indicated the Appellant skipped several meals a t a time over the duration of the program. The journal entries do not indicate the use of protein shakes. (Exhibit A, pp 27-52)

3. On , the Appellant was told during an assessment and treatment plan for obesity that she should add protein shakes to her meal plans and advised to have an average daily caloric intake of calories. (Exhibit A, p 16).

4. From through , the Appellant gained pounds. (Exhibit A, pp 5-52; Testimony).

5. On , , Physician's Assistant (PA) submitted to the MHP a prior authorization request for a bariatric procedure. The prior authorization request included numerous medical records. The medical records indicated the Appellant had lost pounds in the previous 6 months. (Exhibit A, pp 1, 5-52; Testimony).

6. On , the MHP's Medical Director reviewed the prior authorization request using the criteria and the MAHP Bariatric Surgery Guidelines for Coverage. (Exhibit A, pp 2, 3, 53-63; Testimony).

7. On , the MHP sent the Appellant and , letters denying the prior authorization request. The letter indicated the documentation reviewed did not show compliance with the weight loss program. (Exhibit A, pp 3, 66-69; Testimony).

8. On , MAHS received a Request for Hearing from the Appellant. (Exhibit A, p 71).

**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/EPSDT for persons under age 21

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2014, 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,* pp 59, 60.

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:

**3.21 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
October 1, 2015, p 24.*

Apollo Managed Care criteria for Bariatric Surgery for morbid Obesity requires that "[t]he patient must be very motivated to undergo the procedure, have demonstrated reasonable compliance with medical recommendations, and understand the inherent risks of both having and not having the procedure."

Exhibit A, p 55.

MAHP Bariatric Surgery Guidelines for Coverage requires there be documented compliance with a weight loss program including diet, exercise, and behavioral medication for a maximum of one year.

Exhibit A, p 64.

The guidelines relied upon the MHP 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 records provided to the MHP do not indicate the Appellant was compliant with the weight loss program she was enrolled in. The Appellant over the course of the program skipped several meals; consumed items that were not part of her diet (pizza, ice cream, cake, French fries etc.) and gained weight.

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 the Appellant did not meet criteria for approval of bariatric surgery based on the information available at the time of the request and its decision must be affirmed.

**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 Arendt
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of Health and Human Services

Date Mailed:

Date Mailed:

CAA/db

cc:

***** 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.