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. 15-015155-MHP

[redacted], [redacted] [redacted]

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 [redacted]. The Appellant appeared and offered testimony on her own behalf. [redacted], Lead Grievance and Appeals, represented [redacted], the Medicaid Health Plan (MHP).

ISSUE

Did the MHP properly deny the Appellant's prior authorization request for removal of an adjustable band and conversion to sleeve gasterectomy?

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 with the Respondent MHP.

2. In [redacted], the Appellant had an adjustable gastric band placed. (Exhibit A, pp 7, 24, 27).

3. On [redacted], the Appellant was seen at [redacted] to be evaluated for revisional bariatric surgery due to complications with vomiting. (Exhibit A, p 7).

4. On [redacted], the Appellant was seen at [redacted] after experiencing problems with vomiting that began a few months prior and to discuss a revision of her [redacted] lapband procedure. (Exhibit A, p 19).

5. On [redacted] submitted to MHP a prior authorization form on behalf of the Appellant requesting approval for the removal of the Appellant's adjustable band and conversion to a sleeve gastrectomy. (Exhibit A, p 1, 6; Testimony).

6. On [redacted], the MHP sent [redacted] and the Appellant a notice indicating the [redacted] request was denied. The denial indicated the Appellant had an adjustable gastric band placed in [redacted] and the Appellant did not meet the criteria for a corrective revisional bariatric surgery. (Exhibit A, pp 1, 27, 28; Testimony).

7. On [redacted] submitted to MHP a second prior authorization request on behalf of the Appellant requesting removal of the Appellant's adjustable band and conversion to a sleeve gastrectomy. (Exhibit A, pp 1, 30-34; Testimony).

8. On [redacted], the MHP sent [redacted] and the Appellant a notice indicating the [redacted] request was denied. The denial indicated the Appellant did not meet the criteria for a corrective revisional bariatric surgery. (Exhibit a, pp 1, 2, 36-37; Testimony).

9. On [redacted], the MHP received a request for a level 1 review. (Exhibit A, pp 2, 63, 64; Testimony).

10. On [redacted] the Michigan Administrative Hearings System received the Appellant's request for hearing. (Exhibit A, p 4).

11. On [redacted] the MHP level 1 review team met and upheld the previous denials as surgical treatment for obesity is limited to one bariatric surgery peer lifetime unless medically/clinically necessary to correct or reverse surgical complications from a previous bariatric procedure and the Appellant medical records do not indicate the Appellant is experiencing symptoms due to a surgical complication as outlined in MHP policy. (Exhibit A, pp 2, 65-68; Testimony).

12. On [redacted], MHP received a request for a level 2 review. (Exhibit A, pp 2, 70, 71; Testimony).

13. On [redacted] the MHP level 2 review team met and upheld the previous denials. The review team indicated the Appellant was limited to one bariatric surgery per lifetime but that the symptoms she was experiencing could be considered surgery complications and as such she might meet criteria for manipulation, adjustment, repair or removal of the lap band. (Exhibit A, pp 2, 72-75; Testimony).

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.*

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP reviewed the prior approval request under the MHP Priority Health Medical Policy No. 91595-R2 Surgical Treatment of Obesity. (Exhibit A, pp 39-50). The specific policy in question states:

Section I(B)(5):

> Coverage for Medicaid/Healthy Michigan Plan Members is limited to one bariatric surgery per lifetime. Unless Medically/Clinically Necessary (see Corrective Revisional Bariatric Surgery – Section I, C, 2, a-c below), a second bariatric

> surgery is not Covered, even if the initial bariatric surgery occurred prior to Coverage under this plan.

Section I(C)(2)(b):

> In members whose primary bariatric surgery (PBS) was an adjustable gastric band (AGB), Corrective RBS including manipulation, adjustments, repair or removal is considered medically necessary if there are complications (e.g.., port leakage, slippage, erosion) resulting in inability to eat appropriate foods due to persistent symptoms.
>
> Exhibit A, pp 42, 43.

The MHP denied the prior authorization request because the Appellant had already received a previous bariatric procedure and the most recent request for a second bariatric surgery as requested was not medically necessary.

The Appellant had complaints of vomiting and evidence of a herniation of her stomach into her chest cavity. Neither of these medical conditions were shown to be life threatening that could only be treated by a conversion of her adjustable band to a sleeve gasterectomy.[1]

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 and conversion to a gastric sleeve as the Appellant has had one bariatric procedure in her lifetime; the submitted documentation did not establish it was medically necessary to remove her lap band and convert it to the gastric sleeve and the MHP policy has a provision allowing for manipulation, adjustment, repair or removal of the Appellant's lab band if there are complications[2].

As a result, the MHP's determination is upheld based on the available information.

[1] Procedure requested.
[2] Appellant was not pursuing a manipulation, adjustment, repair or removal of her lap band. The Appellant was pursuing a conversion.

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.

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

Date Mailed: [redacted]

Date Mailed: [redacted]

CAA/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.