STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. Box 30763, Lansing, MI 48909
(800) 648-3397; Fax: (517) 373-4147

IN THE MATTER OF:

[redacted],

Docket No. 15-019656 MHP
Case No. [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 [redacted] and continued to [redacted]. [redacted], appeared and offered testimony on the Appellant's behalf. The Appellant did not appear and did not offer testimony. [redacted], appeared on behalf of Meridian Health Plan, the Medicaid Health Plan (MHP). Dr. [redacted], Medical Director, appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's request for a Bariatric Surgery Evaluation?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is a [redacted]-year-old male Medicaid beneficiary who is currently enrolled in the MHP. (Exhibit A, p. 17; Testimony.)

2. On or around [redacted], the MHP received a prior approval request for Bariatric Surgery evaluation for the Appellant. (Exhibit A, pp. 14-37.)

3. The documentation attached to the [redacted] prior approval request included various medical records pertaining to the Appellant. The records did not reveal participation in any kind of medical weight loss program nor did it indicate a weight loss of 5% or more. (Exhibit A, pp. 14-37; Testimony.)

4. On [redacted], the MHP sent the Appellant a notice denying the prior approval request for a Bariatric Surgery Evaluation. (Exhibit A, pp. 39-48; Testimony.)

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 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 MHP Policy and Procedure Manual Policy Number F.04 covers Bariatric Surgery. The applicable policy states that in order to receive surgical intervention for obesity, the beneficiary must amongst other things, have documentation of continued and consistent compliance with MHP established weight loss regimen including diet, exercise, and behavioral modifications for a minimum of one year and that the first six months must be through a structured weight loss program. The MHP Policy and Procedure Manual Policy Number F.18 covers medical weight loss management. The applicable policy states that successful completion of a weight loss program is having lost 5% of their starting weight per session.

Exhibit A, pp. 80, 81, 87.

The guidelines relied upon by the MHP contain certain criteria that must be met in order for a Bariatric Surgery Evaluation to be approved. The criterion is consistent with the Medicaid standard of coverage and is 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 the request.

Here, based on the evidence presented in this case, the MHP properly denied Appellant's request based on MPM and the corresponding MHP Guidelines. The records and testimony provided by the MHP indicate the Appellant did not successfully participate in a medically supervised weight loss plan or lose the 5% of weight required and is therefore not eligible for the Bariatric Surgery Evaluation.

The Appellant's representative argued they were told they needed to meet other criteria and that medical records furnished to the MHP for consideration should have been sufficient as they show participation in a medical weight loss program.

The Appellant's representative, however, was unable to furnish anything to corroborate her claim that someone from the MHP granted prior approval for the sessions with the Appellant's health provider as counting as participation in a medical weight loss program. Nor did the records provided to the MHP show that the office visits were for weight loss. In fact, the records furnished showed they were office visits for other things that ranged from sinus infections to ear aches.

The MHP's 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 a Bariatric Surgery Evaluation 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 a Bariatric Surgery Evaluation.

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

[redacted]
Docket No. 15-019656 MHP
Decision and Order

Date Mailed: February 5, 2016

CAA[redacted]

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.