STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-12359 QHP
[redacted]

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]. [redacted] represented herself at hearing.

[redacted] lead appeals coordinator for [redacted], represented the Medicaid Health Plan (hereinafter MHP or Molina). [redacted], Associate Medical Director for [redacted], was present and testified on behalf of the MHP.

ISSUE

Did the Medicaid Health Plan properly deny Appellant's request for gastric bypass surgery?

FINDINGS OF FACT

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

1. The Appellant is a [redacted] old female Medicaid beneficiary who is currently enrolled in [redacted] of Michigan, a Medicaid Health Plan (MHP).

2. The Appellant's medical conditions include hypertension, angina, diabetes, dyslipedemia, gastroesophageal reflux, menstrual irregularities, osteoarthritis, depression, obstructive sleep apnea and chronic back pain. Her BMI has remained as high as 68.4. (Exhibit 1, pages 11 and 57)

3. On [redacted], the MHP received a request for gastric bypass surgery from the Appellant's physician. (Exhibit 1, page 57)

4. On [redacted], the MHP sent the Appellant an Adequate Action Notice stating that the request for gastric bypass surgery was not authorized because the submitted clinical documentation did not establish all criteria for the procedure had been met. (Exhibit 1, page 3)

5. On [redacted], the Appellant requested an appeal of the MHP determination. (Exhibit 1, page 1)

6. The Appellant submitted additional documentation, which was reviewed by Molina's Appeal Review Committee. The denial of the requested procedure was upheld because one criteria remained unmet, documentation of a twelve month physician supervised weight loss program showing weight loss or stability over the last 24 months. (Exhibit 1, pages 1-2 and 9-10)

7. The Appellant requested a formal, administrative hearing contesting the denial on [redacted].

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 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:

4.22 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
Version Date: October 1, 2009, Page 39

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP representative and MHP witness explained that for a procedure such as gastric bypass surgery, the MHP requires prior approval. In order to achieve prior approval it was further explained that specific criteria must be met, including documentation of a twelve month physician supervised weight loss program that shows weight loss or stability over the last twenty four months.

The MHP testified that the information submitted with the request for did not show that the Appellant met the requirement of participating in the physician supervised weight loss program. The MHP explained that the office notes submitted from the Appellant's physician's office did not show the visits were specifically for a bariatric program, with specific notes addressing weight loss on a monthly basis over the course of a year.

The Appellant testified that she was unable to afford the co-pays to participate in the weight loss program at Beaumont. The Appellant stated that attempted to have her doctor oversee a weight loss program, however she does not always see the same doctor at the clinic. The Appellant explained that she is seen by residents and that she explained to each resident at the office visits that she was there to discuss weight loss. The Appellant acknowledged that the residents may not have charted this properly.

This ALJ has reviewed the progress notes and agrees that they do not document a twelve month physician supervised weight loss program. While weight loss and increased exercise are occasionally noted, most notes show the focus of the visit was treatment for other conditions. (Exhibit 1, pages 16-50)

The MHP can only make a determination using submitted documentation. The MHP provided sufficient evidence that its gastric bypass 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 information, the Appellant did not meet criteria for approval of gastric bypass surgery. As such, the MHP properly denied prior approval of this procedure.

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 gastric bypass surgery.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/18/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 State Office of Administrative Hearings and Rules 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.