STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

[redacted],

Docket No. 2011-34302 QHP
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]. [redacted], the Appellant, appeared on her own behalf. [redacted], Appeals Coordinator, represented [redacted], the Medicaid Health Plan (hereinafter MHP). [redacted] Medical Director, appeared as a witness for [redacted].

ISSUE

Did the Medicaid Health Plan 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 [redacted]-year-old female Medicaid beneficiary who is currently enrolled in [redacted], a Medicaid Health Plan (MHP).

2. On [redacted], the MHP received a request for bariatric surgery from the Appellant's physician. The request indicates that the Appellant has been diagnosed with reflux gastroesophageal, obesity morbid, colitis ulcerative unspecified, and diverticulosis colon without hemorrhage. (Exhibit 1, pages 13-70)

3. The documentation submitted with the prior authorization request included office visit notes from [redacted] through [redacted], [redacted] and [redacted]. These notes document visits at

least monthly during those time frames, but do not indicate the primary focus of the visits was a physician supervised weight loss program. (Exhibit 1, pages 24-70)

4. On [redacted], the MHP sent the Appellant a denial notice stating that the request for bariatric surgery was not authorized because the submitted documentation did not show regular attendance and ongoing weight loss with a physician supervised weight loss program that included a weight loss diet, exercise, and behavior changes for at least one year and done within the last two years. (Exhibit 1, pages 2-3)

5. On [redacted], the Appellant requested a formal, administrative hearing contesting the denial.

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: April 1, 2011, Page 40.*

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The MHP Medical Director explained that for a procedure such as bariatric surgery, the MHP reviews prior approval requests under the Molina Healthcare of Michigan Utilization Guideline for Bariatric Surgery. (Exhibit 1, pages 6-8) The Utilization Guideline for Bariatric Surgery includes a requirement for:

> 4. Physician documented successful participation in a physician supervised weight loss program involving a weight loss diet, exercise, and behavioral modification for a minimum of one (1) year, performed within the last two (2) years. Successful participation is determined at a minimum by documented regular attendance (at least monthly) and demonstration of consistent weight loss. The weight loss program must be medically supervised and provided by a plan provider. A physician's summary letter will not be considered sufficient documentation. The documentation must include medical records/clinical notes of the physician's contemporaneous assessment of the member's progress throughout the course of the weight loss program. (Exhibit 1, page 6)

The Medical Director explained that the documentation submitted with the Appellant's prior authorization request included office notes since [redacted], but they did not document attendance on a monthly basis for at least one year within the last two years, weight loss diets, the plan of care, or a behavior modification plan. He also noted that between [redacted], and [redacted], the Appellant gained 20 pounds. (See Exhibit 1, pages 2, 18 and 24)

The Appellant disagrees with the denial and testified that she goes to the doctor every month. She explained that she was older when she went though the change, and has no metabolism left. The Appellant stated she has hypertension, high cholesterol, bad knees and had her hip replaced. She has pain and can not move like she used to. The Appellant explained the gaps in the office visit notes were from when the MHP stopped covering them. She also stated that her weight goes up and down and diets do not work for her because she gains the weight back once she stops a diet. The Appellant stated that she needs this surgery done to extend her quality of life to be worthwhile and expects she would not have to take as many mediations.

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 information, the Appellant did not meet criteria for approval of bariatric surgery. The submitted documentation does not show at least 12 months of continuous participation in a physician supervised weight loss program within two years prior to the [redacted], prior authorization request. The office visit notes only show monthly attendance from [redacted] through [redacted], then [redacted], [redacted] and [redacted]. (Exhibit 1, pages 24-70) Further, the office notes do not consistently indicate that a weight loss program was a reason for the office visits. For example the [redacted] note indicates medication review, hyperlipidemia and depression as the reasons for the visit, the [redacted] note indicates back pain and right hip pain as the reasons for the visit, and the [redacted], notes indicates lab results, refill Darvocet, and headache as the reasons for the visit. (Exhibit 1, page 42, 44, and 58-59)

The Appellant did not meet the MHP's physician supervised weight loss program criteria for bariatric surgery based on the documentation submitted with the [redacted], prior authorization request. The MHP's determination is upheld.

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.

IT IS THEREFORE ORDERED that:

The Medicaid Health Plan's decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 8/17/2011

***** 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.