STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Docket No. 2011-34325 QHP
Case No.

,

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. , Appeals Coordinator, represented the Medicaid Health Plan (hereinafter MHP). , Medical Director, appeared as a witness for .

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 -year-old female Medicaid beneficiary who has been enrolled in , a Medicaid Health Plan (MHP) since . (Exhibit 1, page 22 and Exhibit 3)

2. On , the MHP received a request for bariatric surgery from the Appellant's physician. The request indicates that the Appellant has been diagnosed with morbid obesity, hypertension, diabetes mellitus, dyslipidemia, gastroesophageal reflux disease, urinary incontinence, menstral irregularities, chronic back pain, arthritis, difficulty walking, depression, unemployed/homebound from obesity, abdominal skin/pannus problems, and lower extremity swelling. (Exhibit 1, pages 15-53)

3. The documentation submitted with the prior authorization request included

progress notes from [redacted] through [redacted]. The progress notes do not document at least monthly attendance in a physician supervised weight loss program for at least one year within two years of the [redacted] prior authorization request. (Exhibit 1, pages 34-50)

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. 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 Appellant provided evidence that she met these criteria, specifically the Medicaid approval letter for bariatric surgery. However, this approval was limited to the authorization date of . (Exhibit 2) The Appellant was enrolled in the MHP effective . Pursuant to her enrollment in the MHP, the Appellant was subject to the MHP's prior authorization procedure. The Appellant's doctor submitted a request for prior authorization to the MHP on . (Exhibit 1, pages 15-53)

Under the DCH-MHP contract provisions, an MHP may devise their own criterion for coverage of medically necessary services, as long as those criterion do not effectively avoid providing medically necessary services.

The MHP Medical Director explained that for a procedure such as bariatric surgery, the MHP reviews prior approval requests under the Utilization Guideline for Bariatric Surgery. (Exhibit 1, pages 8-10) 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 8)

The references section of the Utilization Guidelines supports the Medical Director's testimony that the MHP's criteria conform to professionally accepted standards of care. (Exhibit 1, page 10) These guidelines are also consistent with the Medicaid Provider Manual policy for weight reduction, which indicates that conservative measures to control weight and manage the complications have failed before other weight reduction efforts may be approved and the request for prior authorization must include the medical history, past and current treatment and results, complications encountered, and all weight control methods that have been tried and have failed. The MHP's Utilization Guidelines are allowable as they are consistent with Medicaid policy and are not designed to effectively avoid providing medically necessary services.

The Medical Director asserted that the Appellant did not meet the MHPs physician supervised weight loss program criteria based on the documentation submitted. He explained that the progress notes did not document attendance at least monthly, that weight loss was discussed during each visit, or what diet, exercise and behavior modifications were recommended. (See Exhibit 1, pages 34-50) The Medical Director also testified that there were concerns with the criterion requiring a psychological evaluation, but this was not a reason included in the , denial notice.

The Appellant disagrees with the denial and testified that she has lots of pain from herniated discs in her back. She acknowledged that she does not go to her primary care doctor every month, but stated that she went to a doctor at least every month. The Appellant stated that she always talked about her weight during the office visits to the family medicine practice and did not understand why this was not documented in the submitted progress notes. She further explained that she must lose the weight to have a surgery to fix her back. The Appellant testified that she was only three days from having the surgery when the MHP denied it.

This ALJ sympathizes with the Appellant's frustration at having a Medicaid approval for the bariatric surgery in , but a denial from the MHP the following month. However, the Medicaid approval was only authorized for a single date, . (Exhibit 2) The MHP was not bound by a Medicaid authorization prior to her enrollment in the MHP. The MHP's bariatric surgery prior approval process is consistent with Medicaid policy, is not designed to effectively avoid providing medically necessary services and is allowable under the DCH-MHP contract provisions. The MHP demonstrated that based on the submitted information, the Appellant did not meet their

criteria for approval of bariatric surgery. The submitted progress notes do not show monthly attendance in a physician supervised weight loss program for any twelve month period within two years of the , prior authorization request. Rather, the progress notes showed less than monthly attendance did not document that the weight loss program was discussed during each of the office visits. For example, the note addressed epidural injections and pain management. (Exhibit 1, page 47)

The Appellant was enrolled in the MHP when the prior authorization request was submitted. The Appellant did not meet the MHP's physician supervised weight loss program criteria for bariatric surgery based on the documentation submitted with the , prior authorization request. Accordingly, 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:

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.