

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

██████████,

Appellant

Docket No. 2011-13393 QHP
Case No. 87198405

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. ██████████, represented ██████████, the Medicaid Health Plan (hereinafter MHP). ██████████, 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 ██████████ Medicaid beneficiary who is currently enrolled in ██████████, a Medicaid Health Plan (MHP).
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 super morbid obesity, diabetes, and hypertension. (Exhibit 1, pages 11-46)
3. The documentation submitted with the prior authorization request included a ██████████ mental health evaluation for the bariatric surgery completed by a LMSW. The Bariatric Assessment report does not include any testing. (Exhibit 1, pages 26-27)
4. On ██████████, the MHP sent the Appellant a denial notice stating

that the request for bariatric surgery was not authorized because the submitted documentation did not include a mental health evaluation which included both an interview and a test performed by a licensed mental health doctor, or the two life threatening co-morbidities required under the [REDACTED] Utilization Guideline for Bariatric Surgery. (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: October 1, 2010, Pages 39-40*

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 ██████████ Utilization Guideline for Bariatric Surgery. (Exhibit 1, pages 6-8) The Utilization Guideline for Bariatric Surgery includes a requirement for a psychological evaluation that must include both an interview and an accepted test performed by a licensed psychologist. (Exhibit 1, page 7) The Medical Director explained that the documentation submitted with the Appellant's prior authorization request included an evaluation from a LMSW, which was okay, but there was no testing. (Exhibit 1, pages 26-27) The Medical Director noted that evaluation by the LMSW appears to be a one time evaluation, but other notes show the Appellant is undergoing active treatment from a psychologist. He questioned why the Appellant's psychologist did not complete the evaluation. The Medical Director also testified that the MHP is no longer concerned about the second reason included in the denial notice, lack of two co-morbidities due to the Appellant's body mass index (BMI) of 42. (Medical Director Testimony)

The Appellant testified that when she was told a mental health evaluation was needed, nothing was said about a test being required. She also explained that the mental health provider she was using at the time the evaluation was performed did not accept Medicaid. Therefore she went to a different provider who accepted Medicaid to complete the required mental health evaluation.

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 due to not having a psychological evaluation that included both an interview and an accepted test. As such, the MHP properly denied prior approval of this procedure. However, this does not imply that the Appellant will never qualify for this procedure. The Appellant indicated that her current psychologist accepts Medicaid. She may wish to submit a new prior authorization request for this procedure upon completing the required psychological evaluation that includes both an interview an accepted test.

[REDACTED]
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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: 4/11/2011

***** 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.