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. 2012-37640 QHP

[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], Legal Counsel, represented [redacted], the Medicaid Health Plan ("MHP"). [redacted], appeared as a witness for the MHP.

ISSUE

Did the MHP properly deny Appellant's request for a psychological evaluation required 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], the Respondent MHP.

2. On [redacted] the MHP received a request for a referral for a psychological evaluation required for bariatric surgery for the Appellant. Included was a data collection form used to determine the medical necessity for bariatric services. The documentation submitted with the request indicates that the Appellant has a Body Mass Index ("BMI") greater than or equal to 40, no comorbidities or risk factors, has not undergone any evaluations to rule out other treatable causes, and has not participated in a physician supervised diet program nor been in regular physical activity for a minimum of six months immediately preceding weight management request. (Exhibit 1, pages 2-7)

3. On [redacted] the MHP sent the Appellant a denial notice stating that the request for a psychological evaluation for bariatric surgery was not authorized because the available information did not show that the Appellant had a BMI equal to or greater than 35 as well as comorbidities or risk factors, and there was no documentation that a reasonable medical management program failed to achieve significant weight loss over 12 continuous months within one year of the requested surgery. (Exhibit 1, pages 8-10)

4. On [redacted], the Appellant requested a formal, administrative hearing contesting the denial. (Exhibit 1, page 1)

5. On [redacted], the MHP sent the Appellant a letter, explaining that the criteria for the psychological evaluation required for bariatric surgery was not met based on the information the doctor provided on the form. The letter indicated that if the information was incorrect, the Appellant should contact her doctor so that the correct information could be submitted to the MHP, upon receipt of which her case would be reevaluated. (Exhibit 1, page 21)

6. The MHP has not received any additional information for the Appellant's request bariatric services. (Member Satisfaction Coordinator Testimony)

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.
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> *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: January 1, 2012, Page 38.*

The DCH-MHP contract provisions also allow for prior approval procedures for utilization management purposes. The MHP reviewed the Appellant's prior approval request under [redacted] Interpretation Guideline for Coverage. These Guidelines consider not just the BMI, but also obesity related comorbidities and risk factors, as well as attempts at medical management like physician supervised diet and exercise programs. (Exhibit 1, pages 11-20)

[redacted] explained that in this case, the information provided by the Appellant's doctor did not document any obesity related comorbidities or risk factors nor any prior participation in diet or exercise programs. (See Exhibit 1, pages 2-7). Accordingly, the MHP denied the referral for the required psychological evaluation for bariatric surgery. ([redacted] After

receiving a copy of the Appellant's hearing request, the MHP sent the Appellant a letter explaining that the criteria for the psychological evaluation required for bariatric surgery was not met based on the information the doctor provided on the form. The letter indicated that if the information was incorrect, the Appellant should contact her doctor so that the correct information could be submitted to the MHP, upon receipt of which her case would be reevaluated. (Exhibit 1, page 21) The MHP has not received any additional information for the Appellant's request for bariatric services. (Member Satisfaction Coordinator Testimony

The Appellant disagrees with the denial and testified that other doctors in the past have also requested bariatric surgery for her. The Appellant stated that she does not see the doctor listed on the Weight Management Data Collection Form, rather she has been seeing another doctor at that office for over a year. The Appellant stated that she has tried weight loss programs in the past, but she has disabilities that hold her back. The Appellant reported diagnoses of hypertension, congestive heart failure, and diabetes. She explained that she has a total of 17 major issues wrong with her, and the requested bariatric surgery could help with 5-10 of these health issues. (Appellant Testimony)

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. Specifically, there was no documentation of obesity related comorbidities or risk factors nor of participation in any physician supervised diet or exercise programs. Based on the submitted information, the Appellant does not meet criteria for approval of bariatric surgery. The MHP's determination to deny the referral for a psychological evaluation required for bariatric surgery must be upheld based on the available information.

[redacted] confirmed that the Appellant had an appointment scheduled with her doctor soon after [redacted] telephone hearing proceedings. If she has not already done so, the Appellant may wish to have her doctor submit a new prior authorization request to the MHP with correct documentation of her conditions and past attempts at weight loss to support the referral the required psychological evaluation and bariatric surgery.

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 a psychological evaluation required 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: 5-10-12

***** 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.