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. 2012-47397 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], the Appellant, appeared on her own behalf. [redacted] Inquiry Dispute Appeals Resolution Coordinator, represented Molina Healthcare of Michigan, the Medicaid Health Plan ("MHP"). [redacted] Chief Medical Officer, appeared as a witness for Molina Healthcare of Michigan. [redacted] was present as an observer.

ISSUE

Did the MHP 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] Medicaid beneficiary who is currently enrolled in Molina Healthcare of Michigan, 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 obesity, hypertension, high cholesterol, degenerative joint disease and back pain. [redacted]

3. The documentation submitted with the prior authorization request included a dietician consultation, nursing consultation, surgeon consultation, psychological evaluation, physician letter and office visit notes from [redacted] and lab reports. [redacted]

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 1) attendance and 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, 2) had regular attendance (at least monthly) and showed ongoing weight loss, 3) was in a weight loss program that was medically supervised by a plan provider, 4) had documentation that included medical records or clinical notes of the physician examination at the same time of the member's visits during the weight loss program and not a summary letter from the physician, 5) has a mental health evaluation which included an interview and a test (MMPI, MCMII, MBMD, or PAI) performed by a licensed mental health doctor that states if the member should or should not have the surgery from a mental health point of view; documentation showing if the patient will be complaint (follow instructions) with post surgical requirements (diet, activity, follow up appointments) and the patient's support network post surgery. [redacted]

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 [redacted], 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 2012, Page 38.*

The DCH-MHP contract provisions allow prior approval procedures for utilization management purposes. The Inquiry Dispute Appeals Resolution Coordinator 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 3-5) The Utilization Guideline for Bariatric Surgery includes requirements for:

1. Member is 18 years of age or older.
2. Member's BMI >35 and two (2) associated life threatening co-morbidities, which include but are not limited to:
    - Poorly controlled diabetes mellitus despite optimal medical management

- Symptomatic sleep apnea not controlled by C-Pap
- Severe cardio-pulmonary condition
- Hypertension inadequately controlled with optimal conventional treatment
- Uncontrolled Hyperlipidemia not amenable to optimal conventional treatment

3. Member's BMI >40 with or without co-morbid conditions.
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.
5. A psychological evaluation must be performed in order to determine whether the member qualifies from a psychological perspective for a weight loss surgery.
    - The evaluation must include both an interview and a test preformed by a licensed psychologist.
    - Accepted testing included Minnesota Multiphasic Personality Inventory (MMPI 2), Millon Clinical Multiaxial Inventory III (MCMI III), Millon Behavioral Medicine Diagnostic (MBMD) or Personality Assessment Inventory (PAI), along with Depression/Anxiety Inventory.
    - The written psychological report must indicate the assessment instrument used, interpretation of the results, and how they apply to the patient's appropriateness as a weight loss surgery candidate, the patient's likely compliance with post-surgical requirements (dietary, activity, follow-up appointments), and patient's support network post surgery.
    - The psychologist must make a definitive recommendation as to whether or not he/she believes the patient represents an appropriate

> candidate for surgery. Also, the psychologist must state clearly whether or not he/she believes the patient understands the effects of the procedure.
>
> (rest of list omitted by ALJ)
> Exhibit 1, pages 3-5

The MHP denied the prior authorization request because the submitted documentation did not meet the criteria regarding the medically supervised weight loss program and psychological evaluation. The office visit notes did not show that all aspects of the criteria for the medically supervised weight loss program were met, such as monthly attendance, weight loss, and that the plan included a weight loss diet, exercise and behavior changes. The psychological evaluation was also insufficient to meet the criteria because it did not document that a test was completed. [redacted] Inquiry Dispute Appeals Resolution Coordinator Testimony and Chief Medical Officer Testimony)

The Appellant disagrees with the denial and testified that she has done everything she was asked to do to qualify for the surgery. The Appellant stated she complied with the diet and walking, went to the doctor monthly, went to support groups, and completed the psychological evaluation. The Appellant testified that she lost some weight, then gained it back plus more. The Appellant stated she has high blood pressure, high cholesterol, knee problems and back problems due to her weight gain. [redacted]

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 documentation, the Appellant did not meet criteria for approval of bariatric surgery. For example, the notes provided by the Appellant's doctor's office did not document regular attendance, at least monthly, in a physician supervised weight loss program, which included weight loss diet, exercise and behavioral modification for at least one year within the last two years. The office visit notes only document appointments in [redacted] and do not contain much specific information regarding a weight loss diet, exercise and behavior modification program. [redacted] Similarly, the submitted physiological evaluation did not document that the required testing was completed. [redacted]

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

The Appellant may wish to have her doctor submit a new prior authorization request to the MHP with additional documentation supporting that the criteria for the bariatric surgery, including monthly attendance in a physician supervised weight loss program and psychological evaluation with testing, have been met.

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 Signed: _____

Date Mailed: 7.12.2012

***** 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.