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:

[redacted],

Docket No. 2012-49196 PA
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9; MSA 16.409 and MCL 400.37; MSA 16.437 upon the Appellant's request for a hearing appealing the Department's decision to deny Appellant's request for prior authorization of gastric bypass surgery.

After due notice, a hearing was held [redacted]. The Appellant appeared without representation. She had no witnesses. [redacted], Manager of the Appeal and Review Section, representated the Department. Her witness was [redacted]

ISSUE

Did the Department properly deny Appellant's request for gastric bypass surgery?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. At the time of her request for gastric bypass surgery, the Appellant was a fee for service Medicaid beneficiary. (uncontested)

2. The Appellant is a [redacted] She has no known uncontrolled, life threatening co-morbidities. [redacted]

3. On [redacted], the Department of Community Health prior authorization division received a P.A. request from Henry Ford Hospital [redacted] seeking authorization for gastric bypass surgery for the Appellant. [redacted]

4. The Department's medical consultant, [redacted], reviewed the request for prior authorization and medical documentation submitted in conjunction with the request.

5. The Department's reviewer determined that the Appellant did not have uncontrolled, life threatening co-morbitities. Additionally, she had not had success in participating in a physician supervised weight reduction program. [redacted]

6. On [redacted], the Appellant was advised that the PA surgical request was denied. [redacted]

7. On [redacted] the instant request for hearing was received by the Michigan Administrative Hearing System (MAHS) for the Department of Community Health.

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.

The Medicaid covered benefits are addressed for the practitioners and beneficiaries in the Medicaid Provider manual. The relevant portion for the issue in this case is set forth below.

1.10 PRIOR AUTHORIZATION

Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility. Different types of services requiring PA include:

- Procedures identified as requiring PA on the procedure code databases on the MDCH website;
- Procedures/items that are normally noncovered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery, off-label use drugs, etc.); and
- Referrals for elective services by out-of-state nonenrolled providers.

1.10.A. TO OBTAIN PRIOR AUTHORIZATION

Providers must submit a letter to the MDCH Program Review Division to obtain PA.

(Refer to the Directory Appendix for contact information.) The letter and materials submitted requesting PA must include:

- Beneficiary's name and Medicaid ID number.
- Provider's name, address, NPI number.
- Contact person and phone number.
- A complete description, including Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) procedure codes as appropriate, of the procedure(s) that will be performed.
- The beneficiary's past medical history, including other treatments/procedures that have been tried and the outcome, diagnostic test results/reports, expectations and prognosis for the proposed procedure, and any other information to support the medical need for the service.

Providers receive a written response from MDCH. If the authorization is granted, the provider receives a PA number to report on the claim. The physician obtaining PA must make the PA number available to other providers, such as other practitioners or the hospital, for billing purposes.

If the beneficiary has Medicare and Medicare covers the service, the provider does not have to obtain PA from Medicaid. If Medicare denies a service as not medically necessary, Medicaid does not cover the service even if a PA has been obtained. If Medicare identifies a service as an excluded benefit under Medicare and Medicaid requires PA, the provider must pursue PA from Medicaid and a coverage determination is made. If the beneficiary has commercial insurance that covers the service and the provider reports the coverage correctly on the claim, the provider does not have to obtain PA from Medicaid. If a primary insurer covers a service but requires PA and the provider does not follow the primary insurance PA process, Medicaid does not make payment for the service either.

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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.
>
> Medicaid Provider Manual (MPM) Practitioner, §4.22, January 1, 2012, p. 4-5 and 38

In this case the Department had a physician review the request for prior authorization and accompanying documentation. She ascertained that despite a report of type II diabetes in the letter of medical necessity from Henry Ford Health system, the medical documentation submitted showed no diagnosis or treatment for diabetes. This presented great concern for the reviewer. Furthermore, the documentation submitted indicated the bulk of it had been manufactured, as it were, in [redacted] for the purpose of submitting it to the Department to establish participation in a physician supervised weight loss program. The documentation submitted did not show sufficient involvement (actual physician supervision) of a specific weight loss treatment plan. Nor did it show success in the effort. With only a few pages of exceptions, the documentation did not demonstrate what is expected in order to show the Appellant had actually participated in a physician supervised weight reduction program. The Department reviewer determined, based upon the medical documentation provided, that the Appellant was not suffering any life threatening co-morbidities at the time of the request for prior authorization.

The Appellant's testimony asserted she had her doctor resubmit documentation after the original was shown to contain many errors and inaccuracies. She was asked if she has diabetes or not. She said she does not have the diagnosis yet but she is close and if she does not lose weight she is very likely to develop it. The Appellant sought to have new and additional documentation entered into evidence. This ALJ did not admit it into the evidentiary record because it had not been submitted in conjunction with the request for prior authorization, thus it is not material to whether the Department's determination at the time was correct or not. She was informed she was able to re-submit a request for prior authorization at any time and encouraged to provide the Department with all relevant and accurate documentation.

On review, it is obvious that the Appellant seeks equitable relief far beyond the jurisdiction of this ALJ. The Appellant failed to meet MPM criteria of necessity for controlling a life endangering medical complication – such issues do not confront the Appellant at this time. This ALJ is without authority to alter the Department policy concerning weight reduction surgery.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's request for gastric bypass surgery.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

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 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.