

**STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

Docket No. 2013-53751 QHP

██████████

██████████

██████████

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. ██████████ Legal Counsel, represented ██████████ ██████████, the Medicaid Health Plan ("MHP"). ██████████ Member Satisfaction Coordinator, 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 ██████-year-old female Medicaid beneficiary who is currently enrolled in ██████████, the Respondent MHP.
2. On ██████████ a referral was issued by phone from the primary care physician's office for a psychological evaluation required for bariatric surgery for the Appellant. (Exhibit 1, page 2; Attachment to the Hearing Summary)
3. The MHP denied the request because they had not received the clinical information needed to make a determination. (Member Satisfaction Coordinator Testimony)

4. On ██████████ the MHP sent the Appellant and her doctors a denial notice stating that the request for a psychological evaluation for bariatric surgery was not authorized explaining that the criteria for the psychological evaluation required for bariatric surgery was not met based on the information that was provided. Copies of the forms the MHP utilizes for requests relating to obesity medical, surgical, and weight management requests were included with the denial letter to the physician. (Exhibit 1, pages 2-16)
5. On ██████████ the Appellant requested a formal, administrative hearing contesting the denial. (Exhibit 1, page 1)

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. The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor must operate consistent with all applicable Medicaid provider manuals and publications for coverages 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 2.024.

Although the Contractor must provide the full range of covered services listed below they may choose to provide services over and above those specified. The covered services provided to enrollees under this Contract include, but are not limited to, the following:

- Ambulance and other emergency medical transportation
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease services
- Family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)
- Health education
- Hearing and speech services
- Hearing aids
- Home Health services
- Hospice services (if requested by the enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), up to 45 days
- Restorative or rehabilitative services (in a place of service other than a nursing facility)
- Medically necessary weight reduction services
- Mental health care – maximum of 20 outpatient visits per calendar year
- Out-of-state services authorized by the Contractor
- Outreach for included services, especially pregnancy-related and Well child care
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services (such as those provided by physicians, optometrists and dentists enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Tobacco cessation treatment including pharmaceutical and behavioral support

- Therapies (speech, language, physical, occupational) excluding services provided to persons with development disabilities which are billed through Community Mental Health Services Program (CMHSP) providers or Intermediate School Districts.
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSTDT for persons under age 21

Article 1.020 Scope of [Services],
at §1.022 E (1) contract, 2010, p. 22.

- (1) The major components of the Contractor's utilization management (UM) program 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 UM activities of the Contractor must be integrated with the Contractor's QAPI program.

- (2) Prior Approval Policy and Procedure

The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages 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 UM decisions be made by a health care professional who has

appropriate clinical expertise regarding the service under review.

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Contract, *Supra*, p. 49

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:

4.21WEIGHT REDUCTION [RE-NUMBERED 4/1/13]

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, 2013, Page 38.*

The DCH-MHP contract provisions also allow for prior approval procedures for utilization management purposes. The MHP utilizes the ██████████ Medical Review Criteria Guidelines for Managed Care- Bariatric Surgery for Morbid Obesity and the ██████████ Benefit Interpretation Guideline for Coverage. (Exhibit 1, pages 2 and 17-21)

These criteria are consistent with the Medicaid standard of coverage to only prior authorize medically necessary treatment of obesity when done for the purpose of controlling life-endangering complications, do not effectively avoid providing medically necessary services and are allowable under the DCH-MHP contract provisions.

On ██████████, a referral was issued by phone from the primary care physician's office for a psychological evaluation required for bariatric surgery for the Appellant. (Exhibit 1, page 2; Attachment to the Hearing Summary) The Member Satisfaction Coordinator explained that in this case, the MHP did not receive the clinical information needed to make a determination. Accordingly, the MHP denied the request and provided copies of the forms the MHP utilizes for requests relating to obesity medical, surgical, and weight management requests with the denial letter issued to the physician. (Member Satisfaction Coordinator Testimony; Exhibit 1, pages 2-16)

The Appellant disagrees with the denial and testified she started this process last July after being told she needed to participate in a medically supervised weight loss plan for one year. The Appellant also asserted that she does have 3 or more risk factors. The Appellant believes she meets the criteria for bariatric surgery. (Appellant Testimony)

However, it was clarified that the MHP denied this request for the psychological evaluation required for consideration for bariatric surgery because the information needed to determine if the criteria was met was not submitted. (Member Satisfaction Coordinator Testimony)

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 the Appellant did not meet criteria for approval of bariatric surgery based on the information available at the time of this request. Specifically, the clinical information needed to determine medical necessity was not submitted. The MHP's determination to deny the referral for a psychological evaluation required for bariatric surgery must be upheld based on the available information.

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 the needed clinical documentation to support the referral for the required psychological evaluation for 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 because the clinical information needed to determine medical necessity was not provided.

