



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]

DECISION

HMO/148577

PRELIMINARY RECITALS

Pursuant to a petition filed April 03, 2013, under Wis. Stat. § 49.45(5)(a), and Wis. Admin. Code § HA 3.03, to review a decision by the Medicaid program in regard to a denial of a prior authorization request, a hearing was held on May 07, 2013, via telephone.

The issue for determination is whether Petitioner's provider has submitted information sufficient to demonstrate that Petitioner is eligible for payment by the Wisconsin Medicaid Program (WMAP) for gastric bypass/Roux-en-y surgery.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]
[REDACTED]
[REDACTED]

Respondent:

Department of Health Services
1 West Wilson Street
Madison, Wisconsin 53703

By: Lucy Miller, Nurse Consultant, ForwardHealth

UnitedHealthcare – No appearance

ADMINISTRATIVE LAW JUDGE:

David D. Fleming
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Milwaukee County.
2. This appeal was filed to contest the denial of a prior authorization request seeking Wisconsin Medical Assistance Petitioner Program (WMAP) payment for a gastric bypass surgery. The reason for the denial of Petitioner's request for gastric bypass was that the Department

determined that Petitioner does not have a comorbid condition documented to be life threatening and that is not responsive to appropriate treatment.

DISCUSSION

Under the discretion allowed by *Wis. Stat.*, §49.45(9), the Department of Health Services (DHS) requires MA recipients to participate in HMOs. *Wis. Admin. Code*, § DHS 104.05(2)(a). Medicaid recipients enrolled in HMOs must receive medical services from the HMOs' providers, except for referrals or emergencies. *Wis. Admin. Code*, § DHS 104.05(3).

The Wisconsin Medical Assistance Program (WMAP) covers gastric bypass surgery through the prior authorization process only if there is a medical emergency. *Wis. Stat.* § 49.46(2)(f). The current approval criteria for this procedure states as follows:

The recipient must meet Criteria A or B or C. If any of these are met the recipient must then also meet the requirements in D and E and F and G.

- A. The BMI is over 40kg/m² and there is clinical documentation that a continued morbidly obese status will lead to serious impairment of the patient's health because of comorbid conditions that cannot be optimally corrected with current therapy or demonstrated and documented trial of a minimum of three months.

Such comorbid conditions undergoing current appropriate therapy trial would include, but not be restricted to, congestive heart failure, recurrent venous thrombosis with [or] without pulmonary emboli, uncontrolled diabetes mellitus or demonstrated coronary artery disease with hemodynamically significant arteriolar occlusion leading to documented myocardial dysfunction.

or

- B. The BMI is between 35 and 39 with documented high-risk co-morbid medical conditions that have not responded to medical management and are a threat to life, such as but not limited to: clinically significant obstructive sleep apnea, Pickwickian syndrome, obesity-related cardiomyopathy, coronary heart disease, or medically refractory hypertension. [unchanged from previous regulation]

or

- C. The recipient must have a BMI ≤50kg/m² for approval of procedure codes 43770 – 43774.

and

- D. All candidates should have clinically documented evidence of a minimum of six months of demonstrated adherence to a physician-supervised weight management program including at least three consecutive months of participation in a weight management program prior to the date of surgery in order to improve surgical outcomes, reduce the potential for surgical complications and establish the candidate's ability to comply with post-operative medical care and dietary restrictions. A physician's summary letter is not sufficient documentation. Documentation should include assessment of the patient's participation and progress throughout the course of the program. The patient must also agree to attend a medically supervised post-operative weight management program for a minimum of six months post surgery for the purpose of ongoing dietary, physical activity, behavioral/psychological, and medical education and monitoring.

and

- E. The candidate should receive a pre-operative evaluation by an experienced and knowledgeable multidisciplinary bariatric treatment team composed of health care providers with medical, nutritional and psychological experience. This evaluation should include at a minimum:

1. a complete history and physical examination, specifically evaluating for obesity-related comorbidities that would require preoperative management.
2. evaluation for any correctable endocrinopathy that might contribute to obesity
3. psychological/psychiatric evaluation and clearance to determine the stability of the patient in terms of tolerating the operative procedure and post-operative sequelae, as well as the likelihood of the patient participating in an ongoing weight management program following surgery
4. patients receiving active treatment for a psychiatric disorder must receive evaluation by their treatment provider prior to bariatric surgery, and be cleared for bariatric surgery.
5. dietary assessment and counseling

and

- F. The recipient must be 18 years of age or older and have completed growth.
- G. The bariatric center requesting the prior authorization must be approved by CMS/ASBS guidelines as a Center of Excellence.

Prior Authorization Guidelines Manual, § 117.014.02 - .04 (February 28, 2008).

A similar but not identical provision is contained in BadgerCare Update # 2008-21, March 2008 and the ForwardHealth Criteria for Coverage of All Bariatric Procedures, it reads as follows:

- The member must have one of the following:
 - A BMI of 40 or greater (include clinical documentation that a continued morbidly obese status will lead to serious impairment of the member's health because of comorbid conditions that cannot be optimally corrected with current therapy) with a demonstrated and documented trial of a minimum of three months.
 - Such comorbid conditions undergoing current appropriate therapy would include, but not be limited to, congestive heart failure, recurrent venous thrombosis with or without pulmonary emboli, uncontrolled diabetes mellitus, or demonstrated coronary artery disease with hemodynamically significant arteriolar occlusion leading to myocardial dysfunction.
 - A three-month period of a physician-supervised program including dietary counseling, behavioral modification, and supervised exercise, plus a psychiatric evaluation prior to surgery would be required for those members whose clinical status is stable. This would provide time to stabilize the member's current clinical status, and educate the member through behavioral modification related to eating habits, appropriate exercise, and psychological support to assure the greatest success with weight control after surgery.
 - A BMI between 35 and 39 with documented high-risk comorbid medical conditions that have not responded to medical management and are a threat to life, such as, but not limited to clinically significant obstructive sleep apnea, Pickwickian syndrome, obesity-related cardiomyopathy, coronary heart disease, or medically refractory hypertension.
- Documentation that the member has attempted weight loss in the past without successful long-term weight reduction. These attempts may include, but are not limited to, diet restrictions or supplements, behavior modification, physician-supervised weight loss plans, physical activity programs, commercial or professional programs, and pharmacological therapy.
- For all members who are stable without documented life-threatening comorbidities, documentation must be presented that the member has clinically documented evidence of a minimum of six months of demonstrated adherence to a physician-supervised weight management program including at least three consecutive months of participation in a weight management program prior to the date of surgery in order to improve surgical outcomes, reduce the potential for surgical complications and establish the member's ability to comply with post-operative medical care and dietary restrictions. A physician's summary letter is not

sufficient documentation. Documentation must include assessment of the member's participation and progress throughout the course of the program. The member must also agree to attend a medically supervised post-operative weight management program for a minimum of six months post-surgery for the purpose of ongoing dietary, physical activity, behavioral/psychological, and medical education monitoring.

- The member should receive a preoperative evaluation by an experienced and knowledgeable multidisciplinary bariatric treatment team composed of health care providers with medical, nutritional, and psychological experience. This evaluation must include, at a minimum:
 - A complete history and physical examination, specifically evaluating for obesity-related comorbidities that would require preoperative management.
 - Evaluation for any correctable endocrinopathy that might contribute to obesity.
 - Psychological or psychiatric evaluation and clearance to determine the stability of the member in terms of tolerating the operative procedure and postoperative sequelae, as well as the likelihood of the member participating in an ongoing weight management program following surgery.
 - Members receiving active treatment for a psychiatric disorder must receive evaluation by their treatment provider prior to bariatric surgery and be cleared for bariatric surgery.
 - Dietary assessment and counseling.
 - The member must be 18 years of age or older and have completed growth.
 - The member must have a BMI of 50 or less for approval of LAGB (43770-43774).

The *Prior Authorization Guidelines Manual* makes clear that the requirements for bariatric surgery must all be met and are not stand alone criteria permitting Medicaid payment for the bariatric procedure if a person meets one of the requirements.

Here it is the Medicaid program contention that Petitioner does not have a comorbid condition, thus does not meet the requirements detailed above. Again, the above requires that, among the other requirements, that Petitioner have ‘...comorbid conditions that cannot be optimally corrected with current therapy’ such that it seriously impairs her health.

As this hearing progressed became apparent that Petitioner may, in fact, have a comorbid condition. Specifically, Petitioner reported that she has been using a CPAP (continuous positive airway pressure) machine for at least five years. Further, she indicated that she had a sleep study coming up not long after the hearing date. Why this information was not included by her provider(s) with the PA request is not known.

Unfortunately, as the undersigned to try to impress upon Petitioner the steps she needs to take to be certain that her provider(s) submit information about Petitioner’s use of, and the efficacy of, the CPAP machine she became frustrated and hung up.

I strongly encourage Petitioner to have to her providers resubmit the PA request for the bariatric surgery and be certain to include along with that request: details of the sleep study, details as to Petitioner’s use the CPAP machine and documentation as to its efficacy.

Finally, I note for Petitioner that her provider will not receive a copy of this Decision. Petitioner may provide a copy of this Decision to the provider.

CONCLUSIONS OF LAW

The evidence offered on behalf of Petitioner does not, at this time, demonstrate that Petitioner meets the requirements for Medicaid payment for laparoscopic gastric bypass/Roux-en-y surgery.

THEREFORE, it is

ORDERED

That this appeal is dismissed.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee,
Wisconsin, this 24th day of June, 2013

\sDavid D. Fleming
Administrative Law Judge
Division of Hearings and Appeals



State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on June 24, 2013.

Division of Health Care Access And Accountability