



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[Redacted case name]

DECISION

MPA/164804

PRELIMINARY RECITALS

Pursuant to a petition filed March 19, 2015, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Division of Health Care Access and Accountability in regard to Medical Assistance, a hearing was held on April 28, 2015, via phone. The record was held open, and extended, to give Petitioner's providers an opportunity to supplement the record. The Division of Hearings and Appeals did not receive that supplement.

The issue for determination is whether Petitioner is eligible for payment by the Wisconsin Medicaid Program (WMAP) for gastric bypass surgery.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[Redacted petitioner name]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703
By: Dr. Lora Wiggins, MD, written submission
Division of Health Care Access and Accountability
1 West Wilson Street, Room 272
P.O. Box 309
Madison, WI 53707-0309

ADMINISTRATIVE LAW JUDGE:

David D. Fleming
Division of Hearings and Appeals

FINDINGS OF FACT

- 1. Petitioner (CARES # [Redacted]) is a resident of Waukesha County.

2. A prior authorization request seeking Medicaid payment for lap sleeve gastrectomy was filed on behalf of Petitioner by Wisconsin Bariatrics, SC. on or about January 20, 2015. The procedure code is 43775. Lap sleeve gastrectomy is a form of weight loss/bariatric surgery.
3. As of a November 2014 physician visit Petitioner is 5'8" and weighed 334 pounds with a body mass index of 50.8. Her diagnoses include hypertension, diabetes, low back pain, bipolar disorder, endometriosis and sleep apnea. The sleep apnea is classified as mild after an August 2014 sleep study and the diabetes controlled with oral medication.
4. This prior authorization request was denied. The reason for the denial is that the documentation did not show that Petitioner meets the criteria necessary for Medicaid payment – specifically; a documented high risk, life limiting comorbid medical condition capable of producing a significant decrease in health status that is demonstrated to be unresponsive to the appropriate treatment.

DISCUSSION

Petitioner requests prior authorization for gastric bypass surgery to control her chronic obesity. Medical assistance covers this procedure through the prior authorization process only if there is a medical emergency:

Benefits under this subsection may not include payment for gastric bypass surgery or gastric stapling surgery unless it is performed because of a medical emergency.
Wis. Stat. § 49.46(2)(f).

Before 2001, authorization guidelines for the bypass procedure made approval nearly impossible, because the Division argued that the “medical emergency” requirement meant that the person’s weight had to pose an immediate threat to his or her life. It further contrarily required that if this threat did occur, no prior authorization was necessary. This created a procedure that required prior authorization, but could paradoxically only be authorized and paid without prior authorization.

In 2001, the *Prior Authorization Guidelines Manual*, §117.014.02, changed the approval criteria to the following more attainable requirements: (1) The patient must have acceptable operative risks and be able to participate in treatment and long-term follow-up; *and* (2) have either a Body Mass Index (BMI) of at least 40, or BMI from 35-39 plus a high-risk co-morbid medical condition clinically judged to be life-threatening, such as documented sleep apnea, Pickwickian syndrome, obesity-related cardiomyopathy, or severe diabetes mellitus.

Revised guidelines issued in July, 2005, and March, 2009, attempted to address the inconsistency between the 2001 criteria and other code requirements that more cost-effective means be tried first. They contained approval criteria related to BMI, co-morbid medical conditions that were unresponsive to medical management, documentation of previous supervised weight loss efforts, evaluation by a bariatric team, and attaining age 18.

The *Prior Authorization Guidelines Manual* was amended on December 7, 2005, and again in August, 2011. The change was to provision A1, related to BMI. That provision now reads:

The member has a body mass index greater than 35 with at least one documented high-risk, life-limiting comorbid medical conditions capable of producing a significant decrease in health status that are demonstrated to be unresponsive to appropriate treatment. There is evidence that significant weight loss can substantially improve the following comorbid conditions:

- Sleep apnea.
- Poorly controlled Diabetes Mellitus while compliant with appropriate medication regimen.
- Poorly controlled hypertension while compliant with appropriate medication regimen.

- Obesity-related cardiomyopathy.

See, *ForwardHealth Update*, No. 2011-44 (August, 2011)

The Provider Handbook, found online, also reflects these criteria:

Topic #12177

Bariatric Surgery

All covered bariatric surgery procedures (CPT procedure codes 43644, 43645, 43770-43775, 43843, 43846-43848) require PA. A bariatric procedure that does not meet the PA approval criteria is considered a noncovered service.

Prior Authorization Approval Criteria

The approval criteria for PA requests for covered bariatric surgery procedures include all of the following:

- The member has a BMI greater than 35 with at least one documented high-risk, life limiting comorbid medical conditions capable of producing a significant decrease in health status that are demonstrated to be unresponsive to appropriate treatment. There is evidence that significant weight loss can substantially improve the following comorbid conditions:
 - Sleep apnea.
 - Poorly controlled Diabetes Mellitus while compliant with appropriate medication regimen.
 - Poorly controlled hypertension while compliant with appropriate medication regimen.
 - Obesity related cardiomyopathy.
- The member has been evaluated for adequacy of prior efforts to lose weight. If there have been no or inadequate prior dietary efforts, the member must undergo 6 months of a medically supervised weight reduction program. This is separate from and not satisfied by the dietician counseling required as part of the evaluation for bariatric surgery.
- The member has been free of illicit drug use and alcohol abuse or dependence for the 6 months prior to surgery.
- The member has been obese for at least 5 years.
- The member has had a medical evaluation from the member's primary care physician, assessing preoperative condition and surgical risk and finding the member to be an appropriate candidate.
- The member has received 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 to determine appropriateness for surgery, including an evaluation of 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.
 - For members receiving active treatment for a psychiatric disorder, an evaluation by his or her treatment provider prior to bariatric surgery. The treatment provider must clear the member for bariatric surgery.
 - At least three consecutive months of participation in a weight management program prior to the date of surgery, including dietary counseling, behavioral modification, and supervised exercise, 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.

- Agreement by the member 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.
- The member is 18 years of age or older and has completed growth.
- The member has not had bariatric surgery before or there is clear evidence of compliance with dietary modification and supervised exercise, including appropriate lifestyle changes, for at least two years.
- The bariatric center where the surgery will be performed has been approved by ASBS guidelines as a Center of Excellence and meet one of the following requirements:
 - The center has been certified by the American College of Surgeons as a Level 1 Bariatric Surgery Center.
 - The facility has been certified by the ASBS as a Bariatric Surgery Center of Excellence.
<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=50&s=3&c=638&nt=Bariatric+Surgery>

Petitioner certainly has serious conditions that affect her health and quality of life; they do not, however, meet the requirement that there be a co-morbid condition that is not responsive to appropriate treatment. This request for bariatric surgery does not, therefore, meet the statutory emergency requirement that there be a medical emergency and cannot be approved. None of this means that Petitioner would not benefit from the procedure. Rather, the conclusion is that the Medicaid cannot pay for it under these circumstances. If circumstances change Petitioner may again file a request for bariatric surgery.

CONCLUSIONS OF LAW

That the evidence does not demonstrate that Petitioner meets the criteria necessary for Medicaid payment for gastric bypass surgery at this time.

THEREFORE, it is

ORDERED

That the petition is dismissed.

REQUEST FOR A REHEARING

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision**. Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or 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 filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, Madison, Wisconsin 53703, **and** on those identified in

this decision as “PARTIES IN INTEREST” **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Milwaukee,
Wisconsin, this 31st day of July, 2015

\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 July 31, 2015.

Division of Health Care Access and Accountability