DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
ON REQUEST FOR REVIEW
Docket Number: M-12-559

In the case of	**Claim for**
E.T. (Appellant)	Medicare Advantage (MA) Benefits (Part C)
**** (Beneficiary/Enrollee)	**** (HIC Number)
Pacificare of California (MA Organization (MAO)/plan)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated November 8, 2011. The ALJ found that Pacificare of California, the Medicare Advantage (MA) plan in which the beneficiary is enrolled (plan), is not required to pre-authorize, cover or pay for lap band surgery for the enrollee for treatment of obesity. The ALJ found that the procedure at issue is not covered for the enrollee under the coverage provisions of National Coverage Determinations Manual (CMS IOM Pub. 100-03), chapter 1, section 100.1. The enrollee has asked the Medicare Appeals Council (Council) to review this decision. The appellant's request for review, dated December 28, 2011 and received by the Council on December 30, 2011, with attachments, is entered into the record as Exhibit MAC-1. The MA plan has not responded to the enrollee's request for review.

The regulation codified at 42 C.F.R. § 422.608 states that "[t]he regulations under part 405 of this chapter regarding MAC review apply to matters addressed by this subpart to the extent that they are appropriate." The regulations "under part 405" includes the appeal procedures found at 42 C.F.R. part 405, subpart I. With respect to Medicare "fee-for-service" appeals,

the subpart I procedures pertain primarily to claims subject to the Medicare, Medicaid and SCHIP Benefits Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). 70 Fed. Reg. 11420, 11421-11426 (March 8, 2005. The Council has determined, until there is amendment of 42 C.F.R. part 422 or clarification by the Centers for Medicare & Medicaid Services (CMS), that it is "appropriate" to apply, with certain exceptions, the legal provisions and principles codified in 42 C.F.R. part 405, subpart I to this case.

A managed care organization offering an MA plan must provide enrollees with "basic benefits," which are all items and services covered by Medicare Part A and Part B available to beneficiaries residing in the plan's service area. 42 C.F.R. § 422.101(a). An MA plan must comply with national coverage determinations (NCDs), local coverage determinations (LCDs), and general coverage guidelines included in original Medicare manuals and instructions. 42 C.F.R. § 422.101(b). By regulation, NCDs are also binding on ALJs and the Medicare Appeals Council. 42 C.F.R. § 405.1060. An MA plan may offer enrollees "supplemental benefits" under the terms of the plan's evidence of coverage. 42 C.F.R. § 422.102.

The enrollee, who is diagnosed with obesity, requested pre-authorization from the MA plan for lap band surgery. Under National Coverage Determinations (NCD) Manual, chapter 1, section 100.1, lap band surgery is covered for beneficiaries with: (1) a Body Mass Index (BMI) greater than or equal to 35; (2) at least one co-morbidity related to obesity; and (3) a history of previously unsuccessful medical treatment for obesity. The applicable local coverage determination (LCD), L28238, *LCD for Bariatric Surgery,* provides a non-exhaustive list of obesity-related co-morbidities, including type II diabetes mellitus, dyslipidemia, poorly-controlled hypertension, significant cardiopulmonary disorder, obstructive sleep apnea, severe arthropathy of weight-bearing joints (treatable but for the obesity), pseudotumor cerebri, severe venous stasis disease, obesity related hypoventilation, and non-alcoholic liver disease or steatohepatitis. Exh. 1, at 10. With regard to the requirement that a beneficiary have had previously unsuccessful medical treatment of obesity, LCD L28238 states:

> The National Coverage Analysis (see Appendix) adds that appropriate consideration of medical management options for the co-morbidity(s) is appropriate prior to surgery. Medicare does not impose a specific time period. Medicare

> expects all surgeons to be part of a comprehensive program for the treatment of co-morbid conditions related to obesity and to have applied "principles of good medical care prior to surgery."

Id.

The plan denied coverage of the requested lap band surgery on February 10, 2011, following review by a physician, on the grounds that the enrollee did not meet the Medicare guidelines for coverage of lap band surgery. The determination noted that the beneficiary had a BMI of 35.8, mild hypertension controlled by medication, and no documentation of diabetes or dislipidemia. Exh. 1, at 26. The plan upheld its denial of coverage in a plan reconsideration dated April 8, 2011, which found that beneficiary's BMI was 33.9. Exh. 2, at 2. The case was forwarded to an Independent Review Entity (IRE) for an IRE reconsideration. On May 25, 2011, the IRE found that the plan was not required to cover or pay for lap band surgery, following review by an IRE physician consultant. As summarized in the reconsideration, the physician consultant found that the enrollee's "BMI is too low," although the enrollee "meet[s] the other Medicare criteria for coverage of lap band surgery." Exh. 1, at 15.

The beneficiary then appealed to an ALJ, who held a hearing at which both the enrollee and a representative of the plan testified. On November 8, 2011, the ALJ issued a decision upholding the unfavorable coverage decision of the IRE. In his decision, the ALJ found that the enrollee did not meet the criteria for coverage of the lap band procedure. The ALJ found that the beneficiary's BMI was less than the required 35, whether it was calculated using a beneficiary height of 5'4" or 5'3-1/2". The ALJ stated that office notes from April and May 2010 which indicated a BMI of 36 were six months prior to the date of the request at issue and, in any event, were inconsistent with other medical records during the same period which indicated a BMI of 33. The ALJ noted that the MA plan's representative testified that the enrollee did not have an obesity-related co-morbidity, in part based on a January 13, 2011 office note indicating that the beneficiary had "mild hypertension, but she is noncompliant with medication." ALJ Dec. at 7, citing exh. 5.

In her request for review, the enrollee asserted –

> I have my BMI and it's over 35 plus [a] copy of hypertensive B/P [blood pressure) 220/114 plus note of prediabetes [--] these all make me eligible[.] Sending copies.

Exh. MAC-1. Attached to the request for review were several new documents not already in the record, which the Council has admitted into the record as attachments to Exhibit MAC-1 (the request for review). The first page was a copy of a December 5, 2011 response from a Claims Management Service (which appears to relate to a worker's compensation claim) to a physician's request for pre-approval to furnish the beneficiary a left total knee arthroplasty. This document states that the enrollee meets medical reasonableness and necessity criteria for such procedure. Also attached is a second page, a note from a pain medicine physician asking the adjudicators to "please re-evaluate," and noting that the beneficiary had an "anti-hypertensive regimen" and BP of 220/114 x 3 on two separate dates. An additional treatment note, from the surgeon who requested pre-authorization for the lap band surgery at issue, dated October 10, 2011, states:

> Since I saw her in January, she has tried losing weight through Nutrisystem and exercise.
> She has gained 10 lbs and now weighs 206 with BMI of 36.5.
> She has hypertension; she has developed hypertriglycer-idemia and is now prediabetic per PCP.
> I believe she is a good candidate for lap band surgery.

The Council has carefully considered the record and the exceptions raised in the appellant's request for review. The Council finds that the enrollee now meets the coverage criteria for lap band surgery. Throughout the various appeals levels of this case, the enrollee has been noted to have a BMI at approximately the required level for coverage and to have mild obesity-related co-morbidities. The record now establishes that the enrollee's weight has increased to 206 and thus, at either a height of 5'3" or 5'4," her BMI would be 36.5 or 35.6 (rounded to the nearest tenth), respectively. The enrollee's pain medicine physician indicates that she has had blood pressure of 220/114 x 3 on two separate dates, which is a serious level of hypertension. The surgeon who requested the surgical pre-authorization notes that the enrollee has hypertension and hypertriglyceridemia (high level of triglycerides in the blood) and is pre-diabetic. The physician indicated that the enrollee

had tried since January (a period of ten months) losing weight through Nutrisystem and exercise.

The Council further notes that the record indicates that the beneficiary has been on pain medications for back and knee pain, including methadone and hydrocodone-acetaminophen. The medical records document at least four prior back surgeries and two knee surgeries (exh. 1, at 39), and further indicate that in December 2011, the appellant met medical necessity requirements for a left total knee arthroplasty. In her own personal statement, the enrollee stated that she broke her back, neck, and left leg falling down the stairs at work, that her weight greatly contributes to her pain and that she cannot exercise “like a normal person” because of her injuries. Exh 4, at 1. The record indicates that the enrollee has had a worker’s compensation claim relating to these injuries.

For the reasons stated above, the Council finds that the enrollee now meets the NCD and LCD criteria for coverage of lap band surgery. The Council reverses the ALJ decision and directs that the plan either pre-authorize or furnish the necessary surgery. However, in making this decision, the Council emphasizes that the plan does not have to specifically approve coverage of the surgery from the physician who requested the authorization if this physician is not a network-affiliated physician. While the plan must provide, pre-authorize, or otherwise cover the requested lap band surgery, the plan may require the enrollee to receive the surgery from a qualified network physician or from a specific, pre-authorized out-of-network physician and is not required to authorize a specific physician chosen by the enrollee.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/ Stanley I. Osborne, Jr.
Administrative Appeals Judge

Date: March 14, 2012