

STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 20,387
)
Appeal of)

INTRODUCTION

The petitioner appeals the decision by the Department for Children and Families, Office of Vermont Health Access (OVHA) denying her request for prior approval under Medicaid for coverage of a panniculectomy. The issue is whether the petitioner's circumstances warrant coverage for such surgery within the meaning of the pertinent regulations.

FINDINGS OF FACT

1. The petitioner is a fifty-one-year-old woman with a history of morbid obesity. She underwent gastric bypass surgery in October 2004. Since then, it appears her weight has been under control. In May 2006 her physician submitted a request for prior approval of a panniculectomy, which is the surgical removal of the "abdominal apron" of fat often left after gastric bypass surgery.

2. In his request the petitioner's doctor noted the following:

Her weight has been stable for over one year.

She has difficulty with keeping the fold under her pannus clean and odor free.

She also has a chronic rash and odor from her umbilicus.

The rash has been present for over one year. She has received treatment for the rash.

Her gastric bypass had helped correct her shortness of breath but she still has abdominal discomfort and pulling when she walks.

She also asked about the possibility of correction of the elastoses of her upper arms as she finds her arms extremely heavy and notes that they tire easily.

3. In a decision dated June 7, 2006 the Department denied the request for prior approval. In its decision the Department provided the following rationale:

Cited reason for denial: Per physician reviewer, the requested service is not medically necessary (Medicaid Rule, M-17.) Medical documentation submitted does not establish medical necessity, appears to be cosmetic in nature.

Background information:

Per the OVHA's clinical guidelines a Panniculectomy is considered medically necessary when:

- a) When the panniculus hangs below the level of the pubis **and**
- b) There is evidence of non-healing rashes, infections, or non healing ulcers despite aggressive treatments for at least 5 months **or**
- c) There is difficulty with ambulation and interference with activities of daily living (ADL).

Per the Medical documentation submitted:

- a) The Beneficiary's panniculus does not hang below the pubis
- b) There is no object evidence of aggressive treatment of rash for the required length of time
- c) There is no evidence that the Beneficiary experiences difficulty with ambulation and interference with activities of daily living. In fact, the documentation from [name], ARNP cites her Exercise/activity level as "active, engages in exercise such as swimming, ice skating, walking for 30 minutes 4x week."

4. The hearing in this matter was continued for several months¹ to allow the petitioner to submit further medical opinion from her doctor (either in writing or phone contact with the Department) addressing the Department's rationale for denial. To date, the Department has not been contacted either in writing or by phone by the petitioner's doctor.

ORDER

The Department's decision is affirmed.

REASONS

W.A.M. § M106.2 includes a provision that the Department, in its Provider Manual, will maintain a "complete and current list of all services and items . . . that require prior authorization". In this case there is no dispute that

¹ Status conferences were held on July 25, August 22, and September 15, 2006.

the Department's rationale (see *supra*) accurately set forth its current guidelines concerning panniculectomy, including the size of the panniculus and the severity of skin disorders and physical limitations caused by it.

The regulations under W.A.M. § M106.3 further provide that prior authorization determinations are governed, *inter alia*, by the following:

A request for prior authorization of a covered health service will be approved if the health service:

1. is medically necessary (see M107). . .
4. is the least expensive, appropriate health service available. . .

Supporting information for a prior authorization request must include a completed claim and a completed medical necessity form. Additional information that may be required includes. . .

- the practitioner's detailed and reasoned opinion in support of medical necessity;
- a statement of the alternatives considered and the provider's reasons for rejecting them; and,
- a statement of the practitioner's evaluation of alternatives suggested by the department and the provider's reasons for rejecting them. . .

In this case, despite being given specific instructions and ample time in which to do so, the petitioner's doctor has not addressed or refuted any of the Department's findings (above) regarding the size and severity of the petitioner's

panniculus. Nor did he offer any comment or rebuttal to the Department's conclusions regarding medical necessity and the availability of alternative treatment.

There can be no dispute that the petitioner's circumstances are sympathetic. However, it cannot be concluded that the Department's position denying Medicaid coverage is not based on a reasonable evaluation of the medical evidence submitted by the petitioner's doctor and an accurate reading of the above regulations. In light of the above, the Department's decision that the petitioner's request does not meet the requirements of prior approval must be affirmed.² 3 V.S.A. § 3091(d), Fair Hearing Rule No. 17.

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² When and if the petitioner can submit additional information from her doctor that addresses the Department's concerns she is free to reapply for prior approval of this procedure. The petitioner is also free to show this decision to her doctor to help him understand the issues surrounding coverage under Medicaid guidelines.