MEDICAL POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
06/21/2004	07/15/2016	07/14/2015

Policy Name	Policy Number
Obesity Surgery	**MM-0026**

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

For Medicare plans please reference the below link to search for Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD):

A. SUBJECT

Obesity Surgery

B. BACKGROUND

Surgery for morbid obesity, bariatric surgery, and gastric bypass surgery is a major surgical procedure with significant risk of surgical and post-op complications that should be considered medically necessary only as a treatment alternative when a concerted effort a conventional and conservative management has failed for those who meet the policy criteria below.

Prior authorization request for Morbid Obesity Surgery and supporting information must be submitted by the surgeon intending to perform the procedure. Further supporting information may be presented by the PCP or other practitioners, but unless the prior authorization request is submitted by the attending surgeon, the request will be administratively denied for lack of information.

C. DEFINITIONS

N/A

D. POLICY

I. The surgery should be considered medically necessary if **ALL** of the following conditions are met:
   A. The patient is at least 21 years of age. Members less than 19 years old will be considered only under extreme circumstances.
   B. The BMI (Body Mass Index) and associated conditions suggest surgery is the most prudent treatment:
      1. BMI >50 with or without associated co-morbidities and failed conservative weight loss attempts as per 3B

2. BMI 40-50 with 1 or more significant co-morbidities not well controlled with appropriate treatment that a surgical weight loss treatment is likely to improve
3. BMI 35-40 with 2 or more co-morbid conditions that are not well controlled with appropriate treatment that a surgical weight loss treatment is likely to improve:
    a. The co-morbid condition is either poorly controlled on appropriate medical therapy and would likely improve with weight reduction OR by virtue of family history and existing clinical conditions, the patient would remain high risk for short term co-morbid complications without the surgery

Examples include:

- Poorly controlled hypertension on multi-drug therapy
- Inadequately controlled diabetes despite high does insulin treatment and other therapeutic regimens
- Lipid disorder on maximum drug therapy and lifestyle modification without control

C. Written clinical documentation and supporting information from the attending surgeon must include:
    1. Letter of medical necessity
    2. Evidence that there has been at least a 9 month documented physician supervised trial of diet and exercise within the last 24 months (adapted from NIH recommendations)
    3. Summary of co-morbid conditions
    4. A description of a multi-disciplinary approach to preparing and managing the patient in the pre-operative and peri-operative periods and through an extended post-operative period
    5. Evidence the patient has been evaluated from a psychological standpoint within the past 6 months and which supports that the patient does not have an underlying psychiatric condition which would interfere with the success of the surgery and that the patient will withstand the rigors of the surgery and maintain long-term follow-up care. If the member is under psychiatric care, documentation from their current treating psychiatrist is also required
    6. Supporting letter of medical necessity from the patient's PCP, recommending the surgery and documenting that the patient has undergone medical evaluation to rule out other treatable causes of obesity
D. Patients with a history of non-compliance with medical care and any psychiatric illnesses that may hinder compliance with the post-operative regimen are not suitable for surgery

For Special Needs Plan members, reference the below link to search for Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD):

For Medicare LCD: Number L28482

If there is no NCD or LCD present, reference the CareSource Policy for coverage.

CONDITIONS OF COVERAGE

HCPCS
CPT

Step Therapy
Under some plans, including plans that use an open or closed formulary, some of the medications in this policy may be subject to step-therapy. Refer to the CareSource formulary tool or PDL for further guidance.

AUTHORIZATION PERIOD

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued:	09/21/2004
Date Reviewed:	09/21/2004, 05/25/2005, 12/01/2008, 03/01/2009, 07/01/2011, 07/01/2013, 07/0/2014, 07/15/2015
Date Revised:	05/25/2005, 12/01/2008, 03/01/2009, 07/15/2015

G. REFERENCES

1. NIH conference, Gastrointestinal surgery for severe obesity. NIH Consensus Development Conference Panel, *Ann Intern Med.*1991 Dec 15; 115(12):956-961.
2. Chapman AE, Kiroff G, Game P, et al. Laparoscopic adjustable gastric banding in the treatment of obesity: a. *Surgery,* 2004; 135:326-51.
3. Buchwald H, Avidor Y, Braunwald E, et al. Bariatric surgery: a systemic review and meta-analysis. *JAMA.* 2004;292:1724-37
4. Decision Memo for Bariatric Surgery for the Treatment of Morbid Obesity (CAG-00250R). U.S. Dept. of Health and Human Services, Centers for Medicare and Medicaid Services, February 21, 2006.
5. MCG 19th Edition, 2015.

This guideline contains custom content that has been modified from the standard care guidelines and has not been reviewed or approved by MCG Health, LLC.

The medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.