A. SUBJECT

Obesity Surgery in Adolescents

B. BACKGROUND

This document is to establish a policy to review the medical necessity for coverage of obesity surgery for adolescents.

The prevalence of extreme obesity in U.S. children and adolescents has been estimated at 4%. There is no standard treatment for morbid obesity. Low-calorie diets, exercise, behavioral modification regiments and medical treatment have generally been unsuccessful in long-term weight management for morbidly obese young people.

The early implementation of healthy lifestyles remains the initial direction at impacting the rising epidemic of obesity. There are the rare morbidly obese children who are candidates for bariatric surgery. The intended procedure must not be experimental or investigational, must meet current standard of care guidelines, and any devised utilized must be FDA approved.

C. DEFINITIONS

N/A

D. POLICY

I. The surgery may be considered medically necessary if the following are met:

A. Adolescent candidates for bariatric surgery should be morbidly obese (defined by the World Health Organization as a BMI of equal or greater than 40)

B. These youth will have attained a majority skeletal maturity (equal or greater than 13 years for girls and equal or greater than 15 years of age for boys)
C. Adolescents have experienced failure of 6 continuous months of organized weight loss attempts and have met certain anthropometric, medical (R/O endogenous causes) and psychological evaluation of both patient and family.

D. Potential candidate for bariatric surgery should be referred to specified centers with multi-disciplinary weight management teams that have expertise in meeting the needs of adolescents.

E. Cooperation, compliance and understanding by both the patient and their family are essential. This includes both the pre-operative period as well as post-operative.

F. These adolescents will require a regular, prolonged post-operative follow up.

G. Written clinical documentation and supporting information for the attending surgeon must include:
   1. Letter of medical necessity
   2. Evidence that there have been adequate conservative attempts at weight loss
   3. Summary (support to meeting policy standard #1) of all co-morbid conditions with their conservative treatment
   4. A description of a multi-disciplinary approach to preparing and managing the patient in the pre-operative periods, peri-operative periods and through an extended post-operative period
   5. Evidence the patient has been evaluated from a psychological standpoint
   6. Evidence the patient has the support and understanding of the family
   7. Supporting letter of medical necessity from the PCP

H. The team should include specialists with expertise in adolescent obesity evaluation and management, psychology, nutrition, and physical activity instruction.

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

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

CONDITIONS OF COVERAGE

HCPCS

CPT

AUTHORIZATION PERIOD

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued: 05/15/2009
Date Reviewed: 05/15/2009, 07/1/2011, 03/15/2012, 07/15/2013, 07/15/2014, 07/15/2015
Date Revised: 03/15/2012

G. REFERENCES

1. Assessment of Child and Adolescent Overweight and Obesity: Dec 2007, A Supplement to PEDIATRICS
5. Ludwig DH Childhood Obesity-The shape of things to come. NEJM 2007;357: 2325-2327.

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.