

MEDICAL POLICY STATEMENT INDIANA MEDICAID

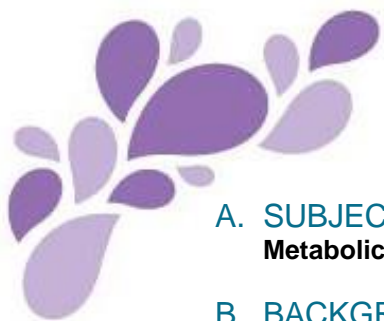
Policy Name	Policy Number	Effective Date
Metabolic and Bariatric Surgery in Adolescents	MM-0258	01/01/2020 - 12/31/2020
Policy Type		
MEDICAL	Administrative	Pharmacy Reimbursement

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.

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A. SUBJECT

Metabolic and Bariatric Surgery in Adolescents

B. BACKGROUND

Childhood obesity continues to be a serious health problem in the United States. The Centers for Disease Control and Prevention (CDC) estimate the prevalence of obesity to be approximately 18.5% affecting 13.7 million children and adolescents (2015-2016). Severely obese children and adolescents are at risk for developing serious comorbidities, including obstructive sleep apnea, diabetes, hypertension, cardiac hypertrophy, and nonalcoholic fatty liver disease (NAFLD). They may also develop depression and suffer from impaired quality of life. The primary goals in achieving optimal health outcomes from our members are to provide noninvasive approaches to prevent obesity by promoting a healthy lifestyle and to improve long-term outcomes. For those adolescents not able to manage their severe obesity through non-surgical interventions, obesity surgery may be an effective intervention.

American Society of Metabolic and Bariatric Surgery (ASMBS)

The ASMBS (2018) recommends that metabolic and bariatric surgery (MBS) should be considered for adolescents with

- Class II obesity defined as 120% of the 95th percentile or BMI ≥ 35 kg/m², with clinical significant co-morbid conditions such as
 - Cardiovascular disease including hyperlipidemia, elevated inflammatory markers, hypertension, and insulin resistance
 - Type 2 diabetes
 - Obstructive Sleep Apnea (Apnea-Hypopnea Index >5)
 - Nonalcoholic Fatty Liver Disease (NAFLD)
 - Idiopathic Intracranial Hypertension and have failed medical management
 - Slipped Capital Femoral Epiphysis (SCFE) or Blount's disease
 - Gastroesophageal Reflux Disease (GERD)
 - Reduced impairment in health (HRQoL) **OR**
- Class III obesity defined as 140% of the 95th percentile or BMI ≥ 40 kg/m² (whichever is lower)

C. DEFINITIONS

- **Body Mass Index For Age Percentile: (BMI):** The CDC defines BMI as a person's weight in kilograms divided by the square of height in meters. BMI is age and sex related for children and teens and is often referred to as BMI-for-age.
- **Adolescent:** Is defined as ages 10-19 year of age.

D. POLICY

- I. A prior authorization is required for adolescent metabolic and bariatric surgery.
- II. Metabolic and bariatric surgery for adolescents is considered medically necessary if **ALL** of the following are met:
 - A. Primary diagnosis is obesity
 1. An extreme obese adolescent with a BMI of ≥ 40 kg/m² or 140% of the 95th percentile (whichever is lower).
OR
 2. An extreme obese adolescent with a BMI of ≥ 35 kg/m² or 120% of the 95th percentile with at least **ONE** of the following comorbidities expected to resolve with surgery:
 - a. Type 2 diabetes.
 - b. Obstructive Sleep Apnea (Apnea-Hypopnea Index >5).
 - c. Heart disease.
 - d. Poorly controlled Hypertension.
 - e. Nonalcoholic Fatty Liver Disease (NAFLD).

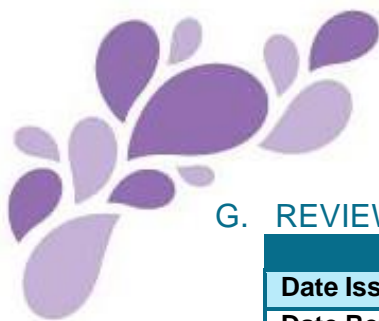


- f. Nonalcoholic Steatohepatitis (NASH).
 - g. Idiopathic Intracranial Hypertension and have failed medical management.
 - h. Slipped Capital Femoral Epiphysis (SCFE) or Blount's disease.
 - i. Gastroesophageal Reflux Disease (GERD).
 - j. Reduced impairment in health (HRQoL). **AND**
 - B. Evidence that parent/caregiver and adolescent are aware of the risks and benefits as well as requirements pre and post surgery. **AND**
 - C. Written clinical documentation and supporting information from the attending surgeon must include:
 - 1. Letter of medical necessity from the Primary Care Physician (PCP) or appropriate specialist.
 - 2. Evidence that member is participating in a multi-disciplinary program to prepare them for surgery as well as through the extended post-operative period.
 - 3. Substance Use Screening results
 - 4. Evidence that harm reduction related to substance use was discussed
 - 5. Evidence that risks of nicotine were discussed
 - 6. Evidence that vitamin B1 levels were monitored and treated as needed prior to surgery
 - 7. Documentation illustrating the member has been evaluated from a psychological standpoint within the past 6 months by the treating behavioral health provider including:
 - a. Any co-existing psychiatric conditions are stable.
 - b. Member can withstand the rigors of surgery.
 - c. Member can adhere with preoperative and postoperative long-term follow-up care including an assessment of ability to make dietary and lifestyle changes.
 - 8. Assessment, listing of diagnoses, and treatment plan. **AND**
 - D. The intended procedure must not be experimental or investigational, must meet current standard of care guidelines, and any device utilized must be FDA approved. **AND**
 - E. The member should not have a current or planned pregnancy within 12 to 18 months of surgery.
 - F. Metabolic and bariatric surgery program is responsible to create a transition plan for member as they transition to an adult program for continued care.
- III. The member should be referred to specified centers for metabolic and bariatric surgery with multi-disciplinary weight management teams that have expertise in meeting the needs of adolescents, including the immediate availability of critical care services, psychology, nutrition, and physical activity instruction.
- IV. Metabolic and bariatric surgery is contraindicated in the following:
 - A. Active suicidality
 - B. Active psychosis
 - C. Active substance abuse
 - D. Ongoing substance abuse problem within the previous year
- V. Repeat procedures are NOT medically necessary unless due to a surgical complication from the original procedure (i.e. fistula, obstruction, stricture). Inadequate weight loss as a result of member noncompliance with treatment plan is NOT considered medically necessary for a repeat surgery.

E. CONDITIONS OF COVERAGE

F. RELATED POLICIES/RULES

Metabolic and Bariatric Surgery in Adults 20 and Older MM-0257



G. REVIEW/REVISION HISTORY

DATES		ACTION
Date Issued	05/15/2009	New Policy.
Date Revised	10/28/2017 5/1/2018	Revisions include Tanner Stages, Growth Charts and BMI charts
Date Effective	01/01/2020	Changed title from obesity surgery. Updated per 2018 guidelines.
Date Archived	12/31/2020	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. REFERENCES

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

Independent medical review - 4/2019

IN-P-0258

Date Issued 05/15/2019

OMPP Approved 09/30/2019

Archived