MEDICAL POLICY STATEMENT
INDIANA MEDICAID

Policy Name	Policy Number	Date Effective
Metabolic and Bariatric Surgery - Revision	MM-1059	12/01/2021-07/31/2022

Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

Medical Policy Statement prepared by CareSource and its affiliates 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 CareSource and its affiliates 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.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A. Subject

Metabolic and Bariatric Surgery - Revision

B. Background

Members may require subsequent surgery because of a complication during the perioperative period. They may also require a revision to correct a technical failure.

C. Definitions

- **Revision -** Maintaining the same anatomy as the primary surgery
- **Inadequate weight loss -** Less than 50% expected weight loss and/or weight remains greater than 40% over ideal body weight (normal body weight BMI parameter = 18.5-24.9).

D. Policy

I. Prior authorizations
   A. A revision procedure to repair a complication or to correct a technical failure requires a prior authorization.
   B. A PA for revision or conversion to Roux-en-Y includes a medical review of documentation.

II. A prior authorization for a surgical revision of a bariatric surgery procedure must include the following documentation:
   A. The reason for the revision procedure
      1. Complication examples include but are not limited to:
         a. Gastrointestinal leakage
         b. Stomal stenosis
         c. Anastomatic leakage
         d. Abscess
         e. Pulmonary embolism (PE)
         f. Wound infection
         g. Wound dehiscence
         h. Gastrointestinal bleeding
         i. Small Bowel Obstruction (SBO)
         j. Incisional hernia
         k. Symptomatic gallbladder disease
      2. Technical failure examples include but are not limited to:
         a. Staple-line disruption – Documented by X-ray or endoscopy
         b. Gastrogastric fistula with weight gain
         c. Expanded outlet – Documented by gastroscopy
         d. Enlarged anastomosis – Documented by gastroscopy
         e. Intolerance to solid food after a band procedure
         f. Intractable reflux after a band procedure
         g. Weight loss as a result of anastomotic stenosis
         h. Stomal ulceration
   B. Date of the original surgery

C. If a revision of bariatric surgery is due to the noncompliant behavior of the member, 6 months of documentation is required and is to include the following:
   1. Member participation in all preoperative and postoperative evaluations and sessions included in the treatment plan.
   2. Member participation in the preoperative and postoperative sessions with a bariatric dietician included in the treatment plan.
   3. An evaluation by a psychiatrist or licensed health service provider in psychology (HSPP) that reflects the absence of behavioral health contraindications to a successful outcome to revision of the bariatric surgery.

E. Conditions of Coverage

N/A

F. Related Policies/Rules

Metabolic and Bariatric Surgery for 18 years of age and older
Metabolic and Bariatric Surgery for <18 years of age

G. Review/Revision History

	DATE	ACTION
Date Issued	07/22/2020	New policy – Separated out from metabolic and bariatric surgery policies.
Date Revised	06/23/2021 09/15/2021	No changes. Removed C. A PA is required for HCPCS procedure code S2083 – Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline.
Date Effective	12/01/2021	
Date Archived	07/31/2022	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

1. Indiana Healthcare Program Bulletin (2014, April 29). BT201420. Retrieved June 17, 2021 from www.provider.indianamedicaid.com
2. Indiana Family & Social Services Administration. (2019, January). Surgical Services. Retrieved June 17, 2021 from www.in.gov

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