CareSource

MEDICAL POLICY STATEMENT
OHIO MEDICAID

Original Issue Date	Next Annual Review	Effective Date
06/21/2004	05/01/2019	05/01/2018
Policy Name		**Policy Number**
Obesity Surgery		MM-0026
Policy Type		
MEDICAL	Administrative / Pharmacy	Reimbursement

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Contents of Policy

A. SUBJECT

Obesity Surgery

B. BACKGROUND

Obesity is a major health threat in the United States facing a large proportion of adults and children. The Centers for Disease Control and Prevention (CDC) estimate that over 37% of adults in the United States, older than the age of 20 are obese (2016). Only tobacco has a higher modifiable risk factor in adult mortality. Obesity will become the number one modifiable risk factor in adult mortality if it continues to trend at the current rate. Obesity related health problems include: hypertension, Type II diabetes, hyperlipidemia, atherosclerosis, heart disease and stroke, diseases of the gallbladder, osteoarthritis, sleep apnea and certain cancers. The early implementation of healthy life styles remains the initial direction at impacting the rising epidemic of obesity. Obesity surgery must not be experimental or investigational, must meet current standard of care guidelines, and any device utilized must be FDA approved.

Bariatric surgery has been shown to have a positive effect on psychosocial functioning, however 20% of patients fail to achieve significant weight loss. A National Institutes of Health (NIH) consensus panel concluded that patients contemplating bariatric surgery should undergo pre-surgery psychological evaluation along with monitoring and addressing of psychological and behavioral factors pre- and post-surgery.

Obesity is clinically defined using the body mass index (BMI). BMI is the most common measure used to measure relative weight in comparison in children and adults.

The National Heart, Lung and Blood Institute (NHLBI) classify the ranges of BMI in adults as follows (NHLBI, 1998):

- <18.5 - Underweight
- 18.5 to 24.9 kg/m$_2$ - Normal
- 25-29.9 kg/m$_2$ - Overweight
- 30-34.9 kg/m$_2$ - Obesity Class I
- 35-39.9 kg/m$_2$ - Obesity Class II
- greater than 40 kg/m$_2$ –Extreme Obesity Class III

Additionally groups of individuals who have a BMI greater than 50 have been identified as super – obese.

Professional Societies

The following professional societies' recommendations are derived from the latest guidelines and scientific based literature available.

American Diabetes Association (ADA)

The ADA recommends bariatric surgery should be a recommended option to treat type 2 diabetes in appropriate surgical candidates with a body mass index (BMI) of 40 or greater regardless of glycemic control, and patients with a BMI of 35.0 to 39.9 with inadequately controlled hyperglycemia despite lifestyle and optimal medical therapy. Surgery should also be considered as an option to treat type 2 diabetic patients with a BMI of 30.0 to 34.9 and inadequately controlled hyperglycemia despite optimal treatment with medications. (2016)

American Society for Metabolic and Bariatric Surgery (ASMBS), American Association of Clinical Endocrinologists (AACE) and The Obesity Society (TOS)

The ASMBS in a joint commission with the AACE and the TOS recommends bariatric surgery be offered for patients with a BMI of 40 or greater and without a coexisting medical condition and for whom the surgery would not be considered high risk and for patients with a BMI of 35 or greater and 1 or more co-morbidities (2013).

Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)
The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) recommends bariatric surgery for the following (2008):

- BMI 35 to 40 with obesity-related co-morbid medical conditions
- BMI ≥ 40 without co-morbidity if the weight adversely affects the patient
- Demonstration that dietary attempts at weight control have been ineffective
- Patients are motivated and well-informed
- Patients are free of psychological disease

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDKD)
The National Institutes of Diabetes and Digestive and Kidney Diseases recommend bariatric surgery for the following (2011):

- BMI of greater than 40
- BMI of greater than 35 with serious comorbidity including:
  - Type 2 Diabetes
  - Heart Disease
  - Severe Sleep Apnea

C. DEFINITIONS

- **Body Mass Index (BMI):** The National Heart, Lung and Blood Institute defines BMI as a measure of body fat based on height and weight that applies to adult men and women.

D. POLICY

I. The surgery should be considered medically necessary if **ALL** of the following conditions are met:
   A. Prior authorization requests and supporting clinical information for Obesity Surgery have been submitted by the surgeon intending to perform the procedure. Further, supporting clinical information may be necessary from the PCP and/or other practitioners.
   B. The patient is at least 20 years of age. Members less than 20 years old will be considered only after sustained efforts to lose weight have been made unsuccessfully and are considered medically necessary under the CareSource Obesity Surgery Adolescent policy.
   C. The BMI (Body Mass Index) and associated conditions suggest surgery is the most prudent treatment:
      1. Patient has a BMI of 40 Obesity Class III or greater
      2. Patient has a BMI of 35 Obesity Class II or greater and at least two of the following co-morbid conditions related to obesity:
         2.1 *Obesity hypoventilation*
         2.2 *Obstructive sleep disorder* diagnosis, not otherwise well-controlled by standard therapies.
         2.3 Poorly controlled hypertension on multi-drug therapy
         2.4 Inadequately controlled diabetes despite optimal medical therapy (as outlined by the ADA).
         2.5 Coronary Artery Disease
         2.6 Pulmonary HTN

      3. 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.

D. Correctable cause for obesity not identified (e.g., endocrine disorder)

E. Written clinical documentation and supporting information from the attending surgeon or relevant specialist(s) have been submitted and includes all of the following:
   1. Letter of medical necessity supporting letter of medical necessity from the PCP or appropriate specialist.
   2. Evidence that there has been at least a 6 month documented physician supervised trial of diet and exercise within the last 24 months.
   3. A description of a multi-disciplinary approach, including, patient demonstrated preparedness, regarding management of the patient during the pre-operative, and an extended post-operative period.
   4. Documentation from the treating psychiatrist, and/or independently-licensed psychologist illustrating the patient has been evaluated from a psychological standpoint within the past 6 months including:
      4.1 Psychiatric diagnoses
      4.2 Relative contraindications such as:
         a. Current acute or inadequately managed mental illness, particularly active psychosis and recent or active suicidal ideation
         b. Active substance abuse or dependence
         c. Inability to participate in informed decision making
         d. An unwillingness or inability to comply with pre and post-surgical protocols
      4.3 Readiness for change: Surgery candidates must be able to tolerate the risks of surgery and comply with a postoperative regimen that requires long-term medical surveillance and lifelong changes in diet and activity. Adherence to behavioral regimens, medication and medical appointments may provide insight into member's ability to be successful after surgery.
      4.4 Patient expectations relative to the surgical and post-surgical process: The psychiatric assessment is used to clarify expectations regarding surgery and to identify psychosocial issues that may require attention over time (e.g. changes in behaviors and relationships)
      4.5 Post-surgical behavioral monitoring: Psychiatric assessment should outline the post-operative plan of care for any behavioral health issues that have been identified.

II. Inadequate weight loss due to individual noncompliance with postoperative nutrition and exercise recommendations is not a medically necessary indication for revision or conversion surgery and is not covered.

E. CONDITIONS OF COVERAGE

HCPCS
CPT

AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

N/A

G. REVIEW/REVISION HISTORY

	DATES	ACTION
Date Issued	09/21/2004	New Policy.
Date Revised	10/17/2017	Annual update
Date Effective	05/01/2018	

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.