



# MEDICAL POLICY STATEMENT

## Ohio Medicaid

Policy Name & Number	Date Effective
Metabolic and Bariatric Surgery-Revision-OH MCD-MM-1061	06/01/2025-05/31/2026
Policy Type	
MEDICAL	

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.

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A. Subject

**Metabolic and Bariatric Surgery: Revision**

B. Background

Revision procedures are typically done because of complications from or a failure of the initial surgical procedure. Complications may include surgical or anatomical complications, as well as nutritional or metabolic complications. A failure of the initial bariatric surgery may result in an inadequate weight loss or a weight regain.

C. Definitions

- **Revisional Bariatric Surgery (RBS)** – surgery to address those patients whose original operation was unsuccessful in achieving satisfactory weight loss goals, or in whom complications from the original operation have occurred.
- **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. CareSource considers surgical revision of a bariatric surgery procedure a covered service when medically necessary.
- II. An inadequate weight loss due only to non-compliance with dietary, behavior, or exercise recommendations is not a medically necessary indication for a revision procedure.
- III. A revision procedure is medically necessary when **all** of the following criteria are met and documented in the medical record:
  - A. surgery/procedure selected is a proven procedure and not considered experimental/investigational and
  - B. a technical failure or major complication has occurred from the initial procedure that cannot be managed medically. Technical failure and major complication examples include the following:
    1. persistent pain and recurrent bleeding occur
    2. chronic stenosis remains after multiple dilations
    3. faulty component or malfunction that cannot be repaired
    4. candy cane roux syndrome
    5. complications that cannot be corrected with band manipulation, adjustments or replacement including band slippage and port leakage or
      - a. obstruction confirmed by imaging studies.

NOTE: Stretching of a stomach pouch formed by a previous bariatric surgery due to overeating is not considered a complication and therefore is not considered an indication for revision.

IV. In the absence of a technical failure or major complication, individuals with weight loss failure  $\geq 2$  years following the initial bariatric surgery procedure must meet medical necessity requirements in the medical policy that applies to an initial bariatric surgery.

V. CareSource does not consider endoscopic bariatric and metabolic therapies such as Intra-gastric balloon (IGB), endoscopic sleeve gastroplasty (ESG), or aspiration therapy (AT) to be weight loss surgery. Individuals with weight loss failure from prior endoscopic therapies must meet medical necessity requirements in the medical policy that applies to an initial bariatric surgery.

E. Conditions of Coverage

N/A

F. Related Policies/Rules

Medical Necessity Determinations  
Metabolic and Bariatric Surgery  
Experimental and Investigational Item or Service

G. Review/Revision History

	DATE	ACTION
<b>Date Issued</b>	07/22/2020	New policy – Separated out from adolescent and adult policies
<b>Date Revised</b>	06/23/2021	PA language replaced by medical necessity criteria. PA enforced by inclusion on the PA list. Updated references.
	06/22/2022	Re-wording of section IV re: medical necessity for revision bariatric surgery. Sec. V. Added IGB, ESG and AT non-coverage. Updated references.
	06/21/2023	Annual review; no changes, Updated references, Approved at committee.
	06/19/2024	Added definition of Revisional bariatric surgery (RBS). Updated references. Approved at Committee.
	02/26/2025	Updated references. Approved at Committee.
<b>Date Effective</b>	06/01/2025	
<b>Date Archived</b>	05/31/2026	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. Eisenberg D, Shikora SA, Aarts E, et al. 2022 American Society for Metabolic and Bariatric Surgery (ASMBS) and International Federal for the Surgery of Obesity and Metabolic Disorders (IFSO): indications for metabolic and bariatric surgery. *Surg Obes Relat Dis.* 2022;18(12):1345-1356. Accessed January 14, 2025. [www.soard.org](http://www.soard.org)

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

2. Ellsmere J. Bariatric operations: late complications with subacute presentations. Updated July 18, 2023. Accessed January 17, 2025. [www.uptodate.com](http://www.uptodate.com)
3. Gastric Restrictive Procedure with Gastric Bypass (S-512). MCG. 28th ed. 2024. Accessed January 14, 2025. [www.careweb.careguidelines.com](http://www.careweb.careguidelines.com)
4. Mechanisk J, Apovian C, et al. Clinical practice Guidelines for the Perioperative Nutrition, metabolic, and nonsurgical support of patients undergoing bariatric procedures – 2020 Update: Cosponsored by American Association of Clinical Endocrinologist/American college of Endocrinology, The obesity society, American Society for metabolic & Bariatric surgery, Obesity medicine Association, and American Society of Anesthesiologists. *Obesity*. 2020;28(4):01-58. doi:10.1002/oby.22719
5. Palep J. Reoperative bariatric surgery. *Recent Advances in Minimal Access Surgery*. JP Medical Ltd; 2019:14-151.
6. *Weight-Loss and Weight-Management Devices*. Federal Drug Administration; 2020. Accessed January 17, 2025. [www.fda.gov](http://www.fda.gov)
7. Yung-Chieh Y, Huang C, Tai C. Psychiatric aspects of bariatric surgery. *Curr Opin Psychiatry*. 2014;27(5):374-379. doi:10.1097/YCO.0000000000000085.

*Independent medical review – 7/2020*

Approved by ODM 3/13/2025

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