Benefit Coverage

<table>
<thead>
<tr>
<th>Covered Benefit for lines of business including:</th>
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<tbody>
<tr>
<td>RiteCare (MED), Substitute Care (SUB), Children with Special Needs (CSN), Rhody Health Partners (RHP), Rhody Health Options (RHO) Unity, Rhody Health Options (MMP) Integrity, Rhody Health Expansion (RHE), Health Benefit Exchange (HBE)</td>
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<th>Excluded from Coverage:</th>
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<td>Extended Family Planning (EFP)</td>
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Overview

Bariatric surgery procedures are performed to treat comorbid conditions associated with morbid obesity. Two types of surgical procedures are employed. Surgery can combine both types of procedures.

- **Malabsorptive procedures** divert food from the stomach to a lower part of the digestive tract where the normal mixing of digestive fluids and absorption of calories is reduced and therefore leads to weight loss.
- **Restrictive procedures** reduce the size of the stomach and limit the volume of intake.

The following are descriptions of bariatric surgery procedures that are conditionally covered when medical necessity criteria are met:

1. **Roux-en-Y Gastric Bypass (RYGB)**
   The RYGB achieves weight loss by gastric restriction and malabsorption. Reduction of the stomach to a small gastric pouch (30 cc) results in feelings of satiety following even small meals. This small pouch is connected to a segment of the jejunum, bypassing the duodenum and very proximal small intestine, thereby reducing absorption. RYGB procedures can be open or laparoscopic.

2. **Biliopancreatic Diversion with Duodenal Switch (BPD/DS)**
   The BPD achieves weight loss by gastric restriction and malabsorption. The stomach is partially resected, but the remaining capacity is generous compared to that achieved with RYGBP. As such, patients eat relatively normal-sized meals and do not need to restrict intake radically, since the most proximal areas of the small intestine (i.e., the duodenum and jejunum) are bypassed, and substantial malabsorption occurs. The partial BPD/DS is a variant of the BPD procedure. It involves resection of the greater curvature of the stomach, preservation of the pyloric sphincter, and transection of the duodenum above the ampulla of Vater with a duodeno-ileal anastomosis and a lower ileo-ileal anastomosis. BPD/DS procedures can be open or laparoscopic.

3. **Laparoscopic Adjustable Gastric Banding (AGB)**
   The AGB achieves weight loss by gastric restriction only. A band creating a gastric pouch with a capacity of approximately 15 to 30 cc's encircles the uppermost portion of the stomach. The band is an inflatable doughnut-shaped balloon, the diameter of which can be adjusted in the clinic by adding or removing saline via a port that is positioned beneath the skin. The bands are adjustable, allowing the size of the gastric outlet to be modified as needed, depending on the rate of a patient's weight loss.
4. **Sleeve Gastrectomy (SG)**
   The SG is a partial gastrectomy in which the majority of the greater curvature of the stomach is removed and a tubular stomach is created. The SG is technically easier to perform and in 2011 it was the second most commonly performed bariatric procedure worldwide.

5. **Conversion** – Procedures that change from an index procedure to a different type of procedure.

6. **Corrective** – Procedures addressing complications or incomplete treatment effect of a previous bariatric operation without changing the type of procedure.

7. **Reversal** - Procedures that restore original anatomy.

8. **Anatomical complications of bariatric surgery** – include anastomotic or staple line leak, fistula, anastomotic stenosis or lumen stricture not amenable to endoscopy, band slippage/prolapse, band erosion, stricture not able to be corrected with non-surgical manipulation, intractable vomiting not amenable to medical treatment and requiring repeated intravenous hydration, TPN and/or feeding tube.

**Coverage Determination**
Neighborhood Health Plan of Rhode Island (NHPRI) covers Bariatric Surgery as a clinical option when determined medically necessary by the Medical Management Department. Although bariatric surgery is not the first option for treatment of obesity, it can be an important option for some Neighborhood members.

<table>
<thead>
<tr>
<th>Requires Authorization</th>
<th>When medical necessity criteria are met, Neighborhood members are allowed coverage for</th>
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<tr>
<td></td>
<td>1. one (1) Laparoscopic Adjustable Gastric Banding per lifetime,</td>
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<tr>
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<td>2. and one (1) Gastric Bypass procedure per lifetime</td>
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**Covered Procedure**

- Laparoscopic Adjustable Gastric Banding
- Open and laparoscopic Roux-en-Y Gastric Bypass
- Open and laparoscopic Biliopancreateic Diversion with duodenal switch
- Laparoscopic Sleeve Gastrectomy
General Criteria

All of the following criteria must be met for authorization.

☐ Age 21 or older, and one of the following:
  ☐ BMI > 40, or
  ☐ BMI between 35 and 40 with life-threatening obesity-related health problems such as Type II diabetes, severe sleep apnea, or cardiac problems with objective documentation (e.g. stress test, angiography, previous MI, CHF)

☐ If the member’s BMI is >40, a medically supervised weight loss program is required for at least a four (4) month period within the last year, prior to the request.

☐ Metabolic causes including, but not limited to, thyroid and adrenal disease have been ruled out or adequately treated, and

☐ The member is not pregnant or breast feeding.

Criteria for Correction/Conversion surgery:

☐ Lack of weight loss or inconsistent weight loss is due directly to an anatomical disruption of the initial procedure and not due to dietary non compliance AND

☐ Met medical necessity criteria for initial bariatric surgery AND

☐ Meets current medical necessity criteria for bariatric surgery AND

☐ Has had regular follow up by a bariatric program and has been compliant with exercise and nutrition guidelines post-operatively (as evidenced by clear documentation) AND

☐ Has had sustained and consistent weight loss commensurate with the length of time since the initial surgery and the development of the anatomical disruption AND

☐ The request for surgery is for one of the following:
  ☐ Gastric bypass with a gastric restriction procedure when the initial procedure was an adjustable gastric band placement
  ☐ Replacement of an adjustable band if there are complications that cannot be corrected with band manipulation or adjustments
  ☐ Gastric bypass procedure when the initial procedure was a sleeve gastrectomy
  ☐ Repair of a fistula when the initial procedure was a Roux-en-Y short limb with a gastric restriction procedure

Please note that the following is the expected excess weight loss at two years for the different procedures:

- Roux-en-Y Gastric Bypass – 70%
- Laparoscopic adjustable gastric banding – 50-60%
- Biliopancreatic diversion with duodenal switch – 70-80%
- Sleeve Gastrectomy – 60%
Documentation submitted with request includes:

- The member’s Primary Care Practitioner or Surgeon must submit the NHPRI Prior Authorization for Gastric Bypass Surgery request form, along with required information to NHPRI for review.
- Specific procedure and planned level of care (ambulatory vs. inpatient)
- Documentation that the member has been informed of the risks of the surgery and of the possible long-term complications
- Documentation of risk factors and co-morbid conditions and the impact obesity and these conditions have on activities of daily living
- Confirmation of medically supervised effort at weight loss for at least four (4) months within the last year either by physician documentation at each visit or involvement in a multidisciplinary surgical preparatory regimen.
- Confirmation of ability to comply with medical therapy and the ability to adhere to nutritional restrictions.
- Confirmation of no evidence of active substance use disorder
- Confirmation that no psychiatric or psychosocial co-morbidities exist which would interfere with adequate follow-up. This may be done in the following ways:
  1. For a member with no history of significant behavioral health issues, the member’s surgeon or primary care practitioner may provide the clearance.
  2. If the member is currently or recently under the care of a behavioral health provider, that provider may provide the clearance.
  3. If the member’s surgeon or primary care provider feels that a behavioral health provider’s clearance is necessary or desired, then referral for that evaluation and clearance is recommended. Neighborhood will provide up to two hours of consultation and/or evaluation for clearance.
  4. If additional evaluation time is needed, then it can be requested through a prior authorization which should include the reasons that additional evaluation is needed.
  5. These evaluations may need to be repeated if the procedure date goes past one year from the initial authorization date.
- Description of the multidisciplinary after care plan

Covered Codes

1. Go to the section for Providers
2. Click on “Resources & FAQ’s”
3. Click on “Medical Management Request Forms” - forms are listed alphabetically by program.

Prior Authorization Forms

For assistance with prior authorizations please contact Clinical Administrative Support at 401-459-6060. Fax authorization forms to 401-459-6023.

For More information on Coding please reference the Authorize Quick Reference Guide.
Exclusions

- “Band over bypass” or AGB revision of prior Roux-en-Y gastric bypass
- “Band over sleeve” or AGB revision of prior sleeve gastrectomy
- Bariatric surgery as a treatment for infertility
- Biliopancreatic diversion without duodenal switch
- Endoscopic bariatric procedures including but not limited to: Rose procedure, StomaphyX endoluminal fastener and delivery system, EndoCinch suturing system, OverStitch suturing device
- Garren-Edwards gastric bubble
- Gastric bypass for gastroparesis
- Gastric Electric stimulation (gastric pacemaker)
- Gastrointestinal liners (e.g. EndoBarrier)
- Gastric plication
- Gastric wrapping
- Horizontal gastric partitioning/gastroplasty
- Intragastric balloon
- Jejunoileal bypass
- Long limb gastric bypass
- Loop gastric bypass
- Mini gastric bypass
- Silastic ring vertical gastric bypass (Fobi pouch)
- Vagus nerve blocking

Annual Review Month: January
Review Dates: 5/07, 11/10/08, 12/29/10, 11/16/12, 12/20/12, 1/15/13, 1/21/2014, 1/6/15, 12/15/2015, 12/15/2016
Revision Dates: 5/04/08, 11/10/08, 12/29/10, 11/16/12, 1/15/13, 1/21/2014, 1/6/15, 12/15/2015, 06/30/2016, 12/15/2016
CMC Review Date: 4/01/04, 5/13/08, 1/11/13, 12, 11/13/12, 1/15/13, 1/21/2014, 1/6/15, 1/5/2016, 1/26/2017
Medical Director Approval Dates: 4/01/04, 5/13/08, 2/14/11, 10/23/12, 11/16/12, 2/12/13, 1/28/2014, 1/6/15, 1/5/2016, 1/26/2017
Disclaimer:

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's coverage plan; a member’s coverage plan will supersed the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.

References:


Gonzalez, Rodrigo, et al. (July 2003). Gastric Bypass for Morbid Obesity in patients 50 years or older: Is Laparoscopic Technique Safer? American Surgeon Vol 69 pages 547-554

J.I. Mechanik et al AACE/TOS/ASMBS. (2013). Bariatric Surgery Clinical Practice Guidelines/ Surgery for Obesity and Related Diseases. 9 159-191

Lim, Robert. (04/2014). Bariatric surgical operations for the management of severe obesity: Descriptions. www.UptoDate.com


The Miriam Hospital Weight Loss Program http://www.lifespan.org/rmh/services/behavhealth/wtmgmt/about.htm