WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

519.4 BARIATRIC SERVICES

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BACKGROUND

Bariatric surgery is performed to treat comorbid conditions associated with morbid obesity. The following descriptions are based on those in the Medicare National Coverage Determination.

Two types of surgical procedures are employed, malabsorptive procedures and restrictive procedures. 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 nutrients cannot occur. Restrictive procedures restrict the size of the stomach and decrease intake.

POLICY

The following are descriptions of bariatric surgery procedures that BMS covers:

- **Roux-en-Y Gastric Bypass (RYGBP) -** The RYGBP 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. RYGBP procedures can be open or laparoscopic.
- **Adjustable Gastric Banding (AGB) -** The AGB achieves weight loss by gastric restriction only. The bands are adjustable and modified as needed, depending on the rate of a patient's weight loss. AGB procedures are laparoscopic only.
- **Sleeve Gastrectomy-** Sleeve gastrectomy procedures can be open or laparoscopic.

The West Virginia Medicaid Program covers **one** medically necessary bariatric surgery procedure per lifetime regardless of the payer responsible for the previous surgery subject to the following conditions:

- Medical Necessity Review and Prior Authorization:

  The member's primary care physician or the bariatric surgeon may initiate the medical necessity review and prior authorization by submitting a request, along with all the required information, to the BMS Utilization Management Contractor (UMC), which will perform medical necessity review and prior authorization based upon the following criteria.

The member must meet the following criteria for bariatric surgery:

1. Must have a Body Mass Index (BMI) of 40 or greater for a minimum of five (5) years, with a co-morbidity that is expected to clinically improve with the proposed surgery; **OR** be at least 100 lbs. or 100% over ideal weight; **OR** have a BMI of 35 or more for a minimum of five (5) years with extreme* co-morbidities (that will be evaluated on a case-by-case basis.

   Recognized comorbidities are:

   A. Coronary heart disease that is reversible with weight loss;
   B. Type II diabetes despite evidence of aggressive medical management;
   C. Osteoarthritis that significantly impairs activity;
   D. Clinically significant obstructive sleep apnea;
   E. Hypertension despite evidence of aggressive treatment and
   F. Obesity related pulmonary hypertension.

*Extreme co-morbidities are medical conditions for which the patient has been nonresponsive or had a poor response to aggressive medical treatment. Extreme comorbidities may include but are not limited to the recognized comorbidities listed above.

2. The member must be between the ages of 18 and 65. (Special considerations apply if the individual is not in the age group and will be evaluated on a case by case basis. Additional documentation will be required and documentation must substantiate completion of bone growth.)

3. Member must not have a past history or currently have any of the following conditions:

   A. Significant liver disease that unduly increases operative and post-operative risk (hepatic cirrhosis, active or chronic Hepatitis B or C);
   B. Current alcohol or chemical dependency;
   C. Severe hypoalbuminemia;
   D. Current pregnancy;
   E. Prior reversal of jejuno-ileal bypass with hepatic dysfunction;
   F. History of total gastrectomy;
   G. A previous significant history of non-compliance with medical and/or surgical treatment.

4. Members with the following diagnoses/conditions require evaluation and clearance by appropriate specialist(s) before prior authorization is approved:

   A. A previous history of bowel resection;
   B. A previous history of cancer or other malignancies within the past five (5) years (not currently in remission);
   C. A large neck or suspected airway or intubation problem that will require airway evaluation and clearance by a licensed board certified anesthesiologist;
   D. Significant cardiomyopathy or myocardial infarctions requiring open heart surgery;
   E. Inflammatory bowel disease or malabsorption syndromes;
   F. Severe renal insufficiency or nephrotic syndrome;
   G. A previous history of significant cardiac or respiratory problems will require evaluation and clearance by a licensed board certified cardiologist/pulmonologist and
   H. A history of previous suicidal tendencies or instances of self-mutilation.

5. All documentation requirements outlined in Section 519.4.1 must be met.

519.4.1 DOCUMENTATION REQUIREMENTS

To ensure member eligibility and program compliance, documentation is required at various stages of the criteria evaluation and subsequent treatment. Procedural stages and documentation required are as follows:

1. Within the two (2) years prior to the request for bariatric surgery, the patient must have participated in a physician supervised nutrition and exercise program, over a consecutive 12 month period, including evaluation and management with a licensed dietician, an increase in physical activity, and behavioral modification. The weight loss must be maintained until the

request is approved and/or the surgery is performed. This program participation must be documented in the medical record and the patient's program must meet the following criteria;

A. The purpose of the weight loss program is to document member commitment to a lifestyle change which would be necessary for ongoing success post-surgery. The requirement of the weight loss program is that there must be a mandatory 10% weight reduction, demonstrated with consistency over a consecutive 12 month period. If pharmacotherapy is utilized to assist with weight loss during this 12 month period, the member will be considered ineligible for bariatric surgery.
B. The weight loss program must include nutrition and exercise components with monitoring by a physician. **Note:** A summary letter is not acceptable.

2. The patient must complete a psychological evaluation, including objective testing, which assesses the ability of the patient to cope with major life changes and other factors pertinent to this surgery. The evaluation must include documentation of family support structure. The preoperative psychological evaluation should be conducted by a licensed psychologist and/or licensed board certified psychiatrist. This evaluator must be qualified in the assessment and diagnosis of mental illness, and have a familiarity with bariatric surgery procedures, follow-up, and required behavioral changes. The UMC will not accept evaluations performed by licensed mental health counselors, social workers, or nurse practitioners.

3. Prior to the surgery, a letter ruling out medically treatable causes of obesity (i.e.: thyroid and endocrine disorders) must be obtained from the primary care physician. Those with treatable causes responsible for their obesity will be considered ineligible for surgery, until such time as they receive proper care and are able to participate in a physician supervised weight loss program. They must still meet the mandatory weight reduction, demonstrated with consistency over a 12 month period.

4. A description of the routine one year post-surgical follow-up plan designed by the bariatric surgeon must be submitted to the UMC with each request. The mandatory treatment plan must include physician-supervised diet and exercise components that may be monitored by either the surgeon or a certified health practitioner (MD, DO, PA, and APRN). The follow-up period will be monitored by the UMC administrator for non-compliance.

5. The member must agree, in writing, to comply with the one-year post surgery, physician supervised, treatment plan. The agreement signed by the patient must include a statement that cosmetic services, including panniculectomy, are not covered by Medicaid.

6. A risk-versus-benefit assessment must be conducted by the primary care provider and documented in the record to determine if the surgery is appropriate for each individual patient.

7. If issues are identified in the evaluation and documentation process that cause concern or that would cause a reasonable prudent surgeon to question the appropriateness of the procedure, then a second opinion is required. All documentation originally required in the initial review must be again provided in the second review.

8. If the member is a tobacco user, he/she must address tobacco cessation with the primary care physician within six (6) months of starting weight management and must be tobacco free for at least six (6) months before surgery.

519.4.2 PSYCHOLOGICAL EVALUATION OF BARIATRIC PATIENTS

The pre-operative psychological evaluation must be conducted by a licensed psychologist and/or licensed board certified psychiatrist qualified in the assessment and diagnosis of mental health illness, and must have familiarity with bariatric surgery procedures, follow-up, and required behavioral changes.

The overall assessment goal is to determine whether the patient has the skills and motivation to comply with the dietary and behavioral changes necessary for a successful surgical outcome.

Following is a non-exclusive list of questions/issues that must be included in the psychological evaluation:

- Is the patient emotionally stable and competent to give consent?
- What is the patient's understanding of the procedure and the post-op nutritional and behavioral changes that lead to a successful outcome?
- What are the patient's expectations? Are the expectations realistic? How does the patient think the surgery will change his/her life?
- What is the patient's weight history and history of weight loss attempts? Does the history provide any clues that will increase the likelihood of a successful outcome?
- What does the patient see as his/her primary challenges?
- What is the nature of the patient's social support system? How does the patient handle stressful circumstances?
- Is there any evidence of past/current history of psychiatric illness, psychiatric symptoms, or psychiatric diagnoses? If so, are these symptoms well treated and stable? If there is a history of previous psychiatric symptoms, did the patient demonstrate the ability to seek appropriate help?
- Is there any evidence of a history of eating disorder and/or difficulties due to substance abuse?
- Is there any evidence of factors that would directly contraindicate surgery (e.g. psychosis, suicidal ideation, or substance abuse)?
- What evidence is there that the patient has the ability to modify his/her behavior? If the patient has present medical problems that require dietary or behavioral changes (e.g. diabetes), how compliant are they with those recommendations? Has the patient already begun to implement changes in eating habits or activity level in anticipation of surgery?
- What can be specifically recommended that would facilitate a successful outcome?

519.4.3 PHYSICIAN AND HOSPITAL CREDENTIALING REQUIREMENTS

All bariatric procedures must be performed by a certified surgeon and at a hospital facility that is certified as a Bariatric Surgery Center of Excellence, as defined by the American College of Surgeons (ACS), or the American Board of Metabolic and Bariatric Surgeons (ASMBS), or the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). The ACS and the ASMBS combined their respective national bariatric surgery accreditation programs into a single unified program MBSAQIP to achieve one national accreditation standard for bariatric surgery centers.

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For purposes of this policy, the surgeon must meet the credentialing requirements and have performed a minimum of fifty (50) bariatric surgical procedures before the procedure will be considered for approval. BMS Provider Enrollment criteria for this specialty must be followed. Please refer to *Chapter 300, Provider Participation Requirements*.

In order to be eligible for reimbursement for bariatric surgery procedures, physicians and hospitals must:

- Provide evidence of credentials at an accredited facility to perform gastrointestinal and biliary surgery.
- Provide documentation that the physician is working within an integrated program for the care of the morbidly obese that provides ancillary services such as specialized nursing care, dietary instruction, counseling, support groups, exercise training and psychological/ psychiatric assistance as needed.
- Provide assurances that surgeons performing these procedures will follow the guidelines to perform open and laparoscopic bariatric surgery established by the ACS, the ASMBS, or the MBSAQIP.

519.4.4 PHYSICIAN PROFESSIONAL SERVICES

Professional services which will be required of the physician performing bariatric surgery include the surgical procedure, the 90-day global post-operative follow-up, and a 12 month assessment period which includes the following: medical management of the member's bariatric care, nutritional and personal lifestyle counseling, and a written report at the end of the 12 month period consisting of: an assessment of the member's weight loss to date, current health status and prognosis, and recommendations for continuing treatment. That 12 month assessment report must be submitted to the member's attending or primary care physician, as well as to the BMS' UMC.

While the bariatric surgeon's association with the member may end following the required 12 month follow-up, the member's continuing care should be managed by the primary care or attending physician throughout the member's lifetime.

519.4.5 PHYSICIAN REIMBURSEMENT

The physician performing the bariatric surgery procedure will be reimbursed through the existing Resource Based Relative Value Scale (RBRVS) payment methodology for the surgical procedure. Reimbursement includes a post-operative follow-up for the global period of 90 days. For the remainder of the required 12 month follow-up period and assessment, the bariatric surgeon may submit claims using the appropriate evaluation and management (E&M) procedure code. After completion of the required 12 month evaluation period, the member may receive follow-up and be medically managed either by the surgeon or primary care physician utilizing appropriate E & M procedure codes.

519.4.6 HOSPITAL REIMBURSEMENT

Participating hospitals will be reimbursed for approved admissions through the DRG reimbursement methodology.

The hospital must be a facility in which the procedures are performed on a regular basis, and that has the

proper equipment and appropriately trained staff for this specialized surgery, as outlined by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program for facilities performing bariatric surgery. The UMC reserves the right to deny a request for bariatric surgery based on the appropriateness of the facility involved.

519.4.7 COVERED SERVICES

Only one procedure will be covered per lifetime regardless of the payer responsible for the previous weight loss procedure. Those failing to lose weight from a prior procedure will not be approved for a second procedure.

Revision surgery to address perioperative or late complications of a bariatric procedure is considered **medically necessary.** These include, but are not limited to, staple-line failure, obstruction, stricture, and non-absorption resulting in hypoglycemia or malnutrition, weight loss of 20% or more below ideal body weight, and band slippage that cannot be corrected with manipulation or adjustment.

Revision of a primary bariatric procedure that has failed due to dilation of the gastric pouch or dilation proximal to an adjustable gastric band (documented by upper gastrointestinal examination or endoscopy) is considered **medically necessary** if the initial procedure was successful in inducing weight loss prior to pouch dilation and the patient has been compliant with a prescribed nutrition and exercise program.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter.

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Policy	Bariatric Services		April 1, 2015