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Clinical Documentation and Prior Authorization Required	√	Type of Review – Case Management	
Not Covered		Type of Review – Precertification Department	√
		Administrative Process (Internal Use Only)	RN

**Note:** Background, product, and disclaimer information is located on the last page.

### Overview

This Medical Necessity Guideline is for the review of Bariatric Surgery. Bariatrics is the branch of medicine that deals with the prevention, control, and treatment of obesity. Bariatric surgery is the surgical treatment of obesity.

### Coverage Guidelines

#### General Information

Tufts Health Plan may authorize coverage of bariatric surgery. Prior to consideration of other eligibility criteria (listed below), the Member must meet the following:

- The Member is at least 18 years of age and considering bariatric surgery.
- The Member has successfully completed the 6-month Tufts Health Plan lifestyle modification program, **iCanChange™** (Please refer to the [iCanChange](#) program description for participation details and requirements). Tufts Health Plan will obtain verification of the participation in **iCanChange** directly from the program sponsor. Members who have not fulfilled this criterion at the time of the bariatric surgery prior authorization request will be automatically enrolled in the **iCanChange** program and will receive program information by mail and electronically.

Upon successful completion of the 6-month **iCanChange** program:

- Members who then elect to defer their request for bariatric surgery may continue enrollment and participation in the **iCanChange** program for up to an additional 12 months. Note: At any time during the additional 12-month period, Members may choose to proceed with the request for prior authorization for bariatric surgery, and if authorized, will discontinue participation in the lifestyle management program.
- Members who wish to request prior authorization for bariatric surgery at the completion of the 6-month **iCanChange** program must meet the following additional criteria:
  - The Member has undergone a preoperative evaluation with a multidisciplinary team including medical, surgical, psychiatric, and nutritional services. Results of such an evaluation must show the Member to be a good operative candidate and be able to cooperate with the post-operative program. In addition, the Member must have no psychiatric issues that could potentially complicate the recuperative process (e.g., substance abuse, psychosis, uncontrolled depression).
  - Bariatric surgery must be performed at facilities in the Tufts Health Plan Designated Provider Network for Bariatric Surgery (DPNBS) in order for the procedure to be covered for HMO and

EPO Members. These facilities must receive “Full Approval” status from either the American Society of Bariatric Surgery/Surgical Review Corporation or the American College of Surgeons, or the “Outpatient Bariatric Surgery Center” designation from the American College of Surgeons. POS and PPO Members must also have the surgery performed at the facilities in the Tufts Health Plan Designated Provider Network for Bariatric Surgery for coverage at the Authorized/In-network level of benefits.

### Criteria for Coverage of Specific Procedures

In addition to meeting all of the above criteria, Members may be eligible for Bariatric Surgical Procedures as follows:

- For Members whose Body Mass Index (BMI) is 40 kg/m<sup>2</sup> or above at the completion of the **iCanChange** program:
  - Members are encouraged by Tufts Health Plan to consider Laparoscopic Adjustable Gastric Banding as the procedure of choice.
  - The requesting Bariatric Surgical Specialist must discuss the pros, cons, and risks of both Laparoscopic Adjustable Gastric Banding and Gastric Bypass Surgery with all of the surgical candidates, and all candidates must be afforded the opportunity to consider both options before making a final decision regarding the surgical procedure to be requested for prior authorization.
  - Bariatric Surgical Specialists or programs who only offer one type of covered bariatric surgical procedure (either Laparoscopic Adjustable Gastric Banding or Gastric Bypass Surgery) will encourage the Member candidate to seek a second opinion from a bariatric surgical specialist who offers both types of procedures, prior to the completion of the prior authorization request.
- Upon successful completion of the **iCanChange** program Tufts Health Plan will consider requests for prior authorization for bariatric surgery on a case-by-case basis for Members with a Body Mass Index (BMI) between 35 and 39.99 kg/m<sup>2</sup> with any of the following conditions:
  - Diabetes Mellitus requiring medication
  - Hypertension requiring medication
  - Medically treated Obstructive Sleep Apnea

### Limitations

As listed above

### References

1. National Institutes of Health Statement on Gastrointestinal Surgery for Severe Obesity, NIH Consensus Statement. 1991; Mar 25-27; 9 (1) 1-20.
2. National Institutes of Health Statement on Gastrointestinal Surgery for Severe Obesity, NIH Consensus Statement, Annals of Int Med. 1991; 115 (12) 956-961.
3. Kolanowski, J, Surgical treatment for morbid obesity. British Medical Journal.1997; 53 (2) 433-444.
4. Balsiger, B., Luque-de Leon, E., Sarr, M. Surgical treatment of obesity: Who is an appropriate candidate? Mayo Clin Proc. 1997; 72: 551-558
5. E. Greenway, F. Endocrinology and Metabolism Clinics of North America. 1996; 25(4) 1005-1021.
6. Capizzi, F.D., Boschi, S., Brulatti, M. et al. Laparoscopic adjustable esophagogastric banding: preliminary results. Obesity Surgery, 2002; 12, 391- 394.
7. Rubenstein, R.E. Laparoscopic adjustable gastric banding at a U.S. Center with a 3-year follow-up. Obesity Surgery, 2002; 2, 380-384.
8. FDA Talk Paper. FDA approves implanted stomach band to treat severe obesity. June 5, 2001.

9. Snow, V. *et. al.* Pharmacologic and surgical management of obesity in primary care: a clinical practice guideline from the American College of Physicians *Annals of Internal Medicine*. 2005;142: 525-531.

## Approval History

Reviewed by the Medical Affairs Medical Policy Committee on January 1, 2007.

Subsequent Endorsement Date(s) and Changes Made: January 1, 2007: New Criteria effective March 6, 2007

- o April 16, 2007: Changes to coverage criteria made regarding Member's BMI and co-morbid medical conditions

## Background, Product, and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for Tufts Health Plan benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. Tufts Health Plan makes coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan revises and updates Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to all fully insured Tufts Health Plan products unless otherwise noted in this guideline or the Member's benefit document. This guideline does not apply to Tufts Health Plan Medicare Preferred or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLink<sup>SM</sup>.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.