Medical Necessity Guidelines:
Bariatric Reoperation for Complications

Effective: September 18, 2019

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:
COMMERCIAL Products
☒Tufts Health Plan Commercial products; Fax: 617.972.9409
☒Tufts Health Freedom Plan products; Fax: 617.972.9409
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☒Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW
Tufts Health Plan may cover bariatric surgery for Members who meet specific guidelines. This guideline is for the review of subsequent bariatric procedures that may be requested.

CLINICAL COVERAGE CRITERIA
Tufts Health Plan may authorize coverage of an elective re-operation for complications after bariatric surgery when the Member meets the following:

- The Member has a symptomatic anatomic abnormality resulting from the first bariatric procedure (e.g., obstruction, band erosion, anastomotic stenosis or ulcer) requiring surgery to resolve symptoms.

LIMITATIONS
Tufts Health Plan considers endoscopic sclerotherapy for bariatric indications (e.g. revision of Roux-en-Y procedure to address weight regain) and endoscopic gastric suturing (e.g. with the Apollo Overstitch™ System) for revision of gastric bypass or as a primary bariatric procedure to be investigational and, therefore, not medically necessary.

CODES
The following CPT codes require prior authorization:

Code	Description
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption

Code	Description
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric band (separate procedure)
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port only

REFERENCES

1. National Institutes of Health Statement on Gastrointestinal Surgery for Severe Obesity, NIH Consensus Statement. 1991; Mar 25-27; 9 (1) 1-20.
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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.
10. Brethauer SA, Kothari S, Sudan R, et al. Systematic review on reoperative bariatric surgery: American Society for Metabolic and Bariatric Surgery Revision Task Force. Surg Obes Relat Dis. 2014. Last accessed July 20, 2017.
11. Hayes, Inc. Revisional surgery for treatment of complications after bariatric surgery. Hayes Directory. July 24, 2014. Annual Review. July 21, 2015. Last accessed 7/13/16. Annual Review July 10, 2017. Last accessed 7/20/2017.
12. Hayes, Inc. OverStitch Endoscopic Suturing System (Apollo Endosurgery Inc.). Hayes Clinical Research Response. May 16, 2018. Last accessed December 6, 2018.

APPROVAL HISTORY

December 11, 2007: Reviewed by the Medical Affairs Medical Policy Committee.

Subsequent endorsement date(s) and changes made:

- October 29, 2008: Reviewed and renewed without changes.
- December 23, 2009: Reviewed and no changes made.
- December 2010: Reviewed by Medical Affairs, Medical Policy. Language reformatted in bullet one; "dilation of gastric pouch or anastomosis" added to bullet two plus language reformatted; language reformatted in bullet three, "band removal for complications" removed. Effective January 2011.
- January 2011: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC): Sleeve gastrectomy code, 43775, added to coverage; effective July 1, 2011.
- January 18, 2012: Reviewed by (IMPAC), no changes.
- December 12, 2012: Reviewed by (IMPAC), no changes. Coding updated.
- December 11, 2013: Reviewed by IMPAC, renewed without changes.
- May 14, 2014: Reviewed by IMPAC for an October 1, 2014 effective date, two CPT codes were added to prior authorization; 43886 and 43888.
- August 6, 2014: Adopted by Tufts Health Plan – Network Health Commercial Plans and Tufts Health Plan – Network Health Medicaid Plans.
- December 10, 2014: Reviewed by IMPAC, renewed without changes.
- March 11, 2015: Reviewed by IMPAC. Document title change from 'Bariatric Reoperation' to 'Bariatric Reoperation for Complications'. Language from bullets 2 and 3 under Coverage Guidelines removed.
- July 23, 2015: Reviewed by IMPAC, renewed without changes.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- March 17, 2016: Coding updated; ICD-9 procedure codes removed.
- July 20, 2016: Reviewed by IMPAC, renewed without changes.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- July 20, 2017: Reviewed by IMPAC, renewed without changes.
- September 22, 2017: Coding updated
- September 12, 2018: Reviewed by IMPAC, renewed without changes
- October 9, 2018: Template and disclaimer updated
- January 9, 2019: Reviewed by IMPAC, update to "Limitations" section.
- September 18, 2019: Reviewed by IMPAC, renewed without changes

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make 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 and 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 our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

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.

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.