

<u>Document ID:</u>	<u>Title: Aetna Medicaid Administrator (AMA) XXXX.XX Bariatric Surgery and Panniculectomy Policy</u>	
<u>Parent Documents: N/A</u>		
<u>Effective Date:</u> <u>02 01 2024</u>	<u>Last Review Date:</u> <u>02 09 2024</u>	<u>Business Process Owner (BPO):</u>
<u>Exhibit(s): NA</u>		
Document Type: Policy and Procedure		

## **PURPOSE**

**This policy describes the health plan's process for the prior authorization decision-making conditions in which Bariatric Surgery and Panniculectomy may be authorized according to the directives from state of Louisiana Medicaid.**

## **SCOPE**

**This policy applies to the Louisiana Prior Authorization staff and all colleagues processing Louisiana authorization requests for Bariatric Surgery and Panniculectomy.**

## **POLICY**

**It is the policy of the Plan that specific state directives, in addition to MCG® criteria are used when processing Bariatric Surgery and Panniculectomy surgeries. Louisiana state qualifications, authorization and documentation requirements must be met. Louisiana Medicaid covers bariatric surgery, consisting of open or laparoscopic procedures that revise the gastrointestinal anatomy to restrict the size of the stomach, reduce absorption of nutrients, or both.**

## **STANDARD**

### **Member Criteria and Prior Authorization Requirements<sup>1</sup>**

**Coverage of bariatric surgery requires prior authorization. All Providers (both facility and ordering physicians) must be registered in the state and the health plan's registry. The provider should be a preferred provider for the health plan.**

**To be eligible for bariatric surgery, members must meet the following criteria:**

- **Received a preoperative evaluation within the previous 12 months that is conducted by a multidisciplinary team including, at a minimum, a physician, nutritionist or dietician, and a licensed qualified mental health professional.**
- **For beneficiaries under the age of 18, the multidisciplinary team must have pediatric expertise.**

**For all beneficiaries, the preoperative evaluation must document all of the following:**

**<sup>1</sup> 2023 Louisiana Medicaid Service Manual Chapter 27.1 Independent Laboratories , page 1 of 1 and Chapter 5.1 Professional Services Manual pg.1-6 Genetic testing..**

- A determination that previous attempt(s) at weight loss have been unsuccessful and that future attempts, other than bariatric surgery, are not likely to be successful; and
- A determination that the beneficiary is capable of adhering to the post-surgery diet and follow-up care; and
- For individuals capable of becoming pregnant, counseling to avoid pregnancy preoperatively and for at least 12 months postoperatively and until weight has stabilized.

**Beneficiaries aged 18 and older must have:**

- A body mass index equal to or greater than 40 kg/m<sup>2</sup>, or more than 100 pounds overweight; or
- A body mass index of greater or equal to 35 kg/m<sup>2</sup> with one or more of the following comorbidities related to obesity:
  - Type 2 diabetes mellitus;
  - Cardiovascular disease (e.g., stroke, myocardial infarction,
  - Poorly controlled hypertension (systemic blood pressure greater than 140 mm Hg or diastolic blood pressure 90 mm Hg or greater, despite pharmacotherapy);
  - History of coronary artery disease with a surgical intervention such as coronary artery bypass or percutaneous transluminal coronary angioplasty;
  - History of cardiomyopathy;
  - Obstructive sleep apnea confirmed on polysomnography with an AHI or RDI of ≥ 30; or
  - Any other comorbidity related to obesity that is determined by the preoperative evaluation to be improved by weight loss; or
  - A body mass index of 30 to 34.9 kg/m<sup>2</sup> with type 2 diabetes mellitus if hyperglycemia is inadequately controlled despite optimal medical control by oral or injectable medications.
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- Members Aged 13 through 17 years old must have:
  - A body mass index equal to or greater than 40 kg/m<sup>2</sup> or 140% of the 95th percentile for age and sex, whichever is lower; or
  - A body mass index of 35 to 39.9 kg/m<sup>2</sup> or 120% of the 95th percentile for age and sex, whichever is lower, with one or more comorbidities related to obesity:
  - obstructive sleep apnea confirmed on polysomnography with an AHI > 5;
  - type 2 diabetes mellitus;
  - idiopathic intracranial hypertension;
  - nonalcoholic steatohepatitis;

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- Blount's disease;
- Slipped capital femoral epiphysis;
- Gastroesophageal reflux disease;
- Hypertension; or
- Any other comorbidity related to obesity that is determined by the preoperative evaluation to be improved by weight loss.

**Requests for beneficiaries under the age of 13 will be reviewed for medical necessity on a case-by-case basis.**

### **Panniculectomy Subsequent to Bariatric Surgery**

**Panniculectomy after bariatric surgery is considered medically necessary when all of the following criteria are met:**

- The beneficiary had bariatric surgery at least 18 months prior and the beneficiary's weight has been stable for at least 6 months; and
- The pannus is at or below the level of the pubic symphysis; and
- The pannus causes significant consequences, as indicated by at least one of the following:
  - Cellulitis, other infections, skin ulcerations, or persistent dermatitis that has failed to respond to at least 3 months of non-surgical treatment; or
  - Functional impairment such as interference with ambulation.

### **Prior Authorization**

- Coverage of bariatric surgery requires prior authorization.
- All Providers (both facility and ordering physicians) must be registered in the state and the health plan's registry. The provider should be a preferred provider for the health plan .

### **APPLICABLE CPT CODES**

**This policy applies the additional definitions, qualifications, criteria and documentation requirements to the procedure codes listed below. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.**

<b><u>HCPCS</u></b>	<b><u>Description</u></b>
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<b><u>43289</u></b>	<b><u>Endoscopic Bariatric Surgery</u></b>
<b><u>43499</u></b>	<b><u>Band over Bypass</u></b>
<b><u>43659</u></b>	<b><u>Mini Gastric Bypass with One Anastomosis</u></b>
<b><u>43999</u></b>	<b><u>Intragastric Balloon</u></b>
<b><u>43770</u></b>	<b><u>Band over Bypass; or Band over Sleeve</u></b>
<b><u>43771</u></b>	<b><u>Laparoscopic Bariatric Surgery</u></b>
<b><u>43772</u></b>	<b><u>Laparoscopic Bariatric Surgery-Gastric Restrictive</u></b>
<b><u>43774</u></b>	<b><u>Laparoscopic Bariatric Surgery – Gastric removal or reduction</u></b>
<b><u>43775</u></b>	<b><u>Laparoscopic Bariatric Surgery – Gastric Restrictive sleeve</u></b>
<b><u>43842</u></b>	<b><u>Vertical Band Gastroplasty</u></b>
<b><u>43843</u></b>	<b><u>Adjustable Silicone Gastric Banding or Sleeve gastrectomy</u></b>
<b><u>43845</u></b>	<b><u>Biliopancreatic Diversion with Duodenal switch</u></b>
<b><u>43846</u></b>	<b><u>Roux-n-Y Gastric Bypass</u></b>
<b><u>43847</u></b>	<b><u>Roux-n-Y Gastric Bypass (greater than 150cm)</u></b>
<b><u>43899</u></b>	<b><u>Surgical Procedure on the Stomach</u></b>
<b><u>43999</u></b>	<b><u>Single anastomosis duodenal-ileal bypass with sleeve gastrectomy</u></b>
<b><u>44238</u></b>	<b><u>Intestinal Jejunioileal Bypass</u></b>

#### **DEFINITIONS:**

<b><u>Bariatric Surgery</u></b>	<b><u>Open or laparoscopic procedures that revise the gastrointestinal anatomy to restrict the size of the stomach, reduce absorption of nutrients, or both for the purpose of weight reduction.</u></b>
<b><u>Endoscopic</u></b>	<b><u>A procedure to introduce an instrument to be able to give a view the internal parts or organs.</u></b>
<b><u>Gastroplasty</u></b>	<b><u>A surgical procedure to reduce the size of the stomach to promote the feeling of fullness leading to weight loss.</u></b>
<b><u>Gastric</u></b>	<b><u>Involving the stomach</u></b>
<b><u>Laparoscopic</u></b>	<b><u>A surgical procedure in which a fiber-optic instrument is inserted through the abdominal wall to view the organs in the abdomen or to permit a surgical procedure.</u></b>
<b><u>MCG ®</u></b>	<b><u>A set of nationally standardized criteria used to make medical necessity determinations for authorization requests.</u></b>

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<b><u>Panniculectomy</u></b>	<b><u>A surgical procedure to remove excess hanging skin and fat from the lower abdomen.</u></b>

**REVIEW AND REVISION HISTORY**

<b><u>Date</u></b>	<b><u>Revision No.</u></b>	<b><u>Reason for Change</u></b>	<b><u>Sections Affected</u></b>
<b><u>2/9/2024</u></b>	<b><u>New Policy</u></b>		<b><u>All</u></b>

**Aetna Better Health of Louisiana**

**Jess R. Hall**  
**Chief Executive Officer**

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**Chief Medical Officer**

**Reference/Resources**

- **2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract,**
- **2023 Louisiana Medicaid Managed Care Organization (MCO) Manual**
- **2023 Louisiana Medicaid Services Manual Chapter 5, 1 Professional Services**
- **Aetna Medicaid Administrator (AMA) 7100.05 Prior Authorization Policy – Louisiana Amendment**