

Blue Cross Blue Shield of Michigan
Medicare Advantage Private Fee-for-Service

Weight Loss Surgery

January 1, 2008
Updated October 1, 2008

WEIGHT LOSS SURGERY¹

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

ORIGINAL MEDICARE

Under Original Medicare, a beneficiary may be eligible for bariatric surgery if he or she:

- Is obese with a body mass index > 35
- Suffers from at least one obesity related comorbid condition, such as diabetes or hypertension
- Has been unsuccessful with other medical treatments for obesity

If the beneficiary meets these criteria, Original Medicare will cover open and laparoscopic roux-en-Y gastric bypass, open and laparoscopic biliopancreatic diversion with duodenal switch, and laparoscopic adjustable gastric banding.

These procedures are only covered when performed at facilities that are:

- Certified by the American College of Surgeons as a level 1 bariatric surgery center (program standards and requirements in effect on February 15, 2006).
- Certified by the American Society for Bariatric Surgery as a bariatric surgery center of excellence.

A list of approved facilities and their approval dates is available on the Centers for Medicare & Medicaid Services Website at:

<http://www.cms.hhs.gov/center/coverage.asp>, and published in the Federal Register.

The following bariatric surgical procedures are non-covered under Original Medicare:

- Open adjustable gastric banding
- Open and laparoscopic sleeve gastrectomy
- Open and laparoscopic vertical banded gastroplasty

¹ CMS - National Coverage Determination policy - GSURG-042 "Bariatric Surgery for Morbid Obesity"
http://www.wpsmedicare.com/part_b/policy/gsurg042.pdf

In addition, the safety of intestinal bypass surgery and the long term safety and efficacy of the gastric balloon have not been established. These procedures do not meet the reasonable and necessary provisions of §1862(a) (1) of Title XVIII of the Social Security Act² and are therefore not covered under Original Medicare.

Supplemented fasting is not covered under the Original Medicare program as a general treatment for obesity. However, where weight loss is necessary before surgery in order to ameliorate the complications posed by obesity when it coexists with pathological conditions such as cardiac and respiratory diseases, diabetes, or hypertension (and other more conservative techniques to achieve this end are not regarded as appropriate), supplemented fasting with adequate monitoring of the patient is eligible for coverage on a case-by-case basis or pursuant to a local coverage determination. The risks associated with the achievement of rapid weight loss must be carefully balanced against the risk posed by the condition requiring surgical treatment.

MEDICARE ADVANTAGE

Coverage for additional weight loss surgery benefits is provided to members under select Medicare Advantage private fee-for-service plans. The scope of the benefit and member cost-sharing are determined by the group.

Additional Surgical procedures for severe obesity are covered if all of the following criteria are met:

- The patient has a BMI >40 or a BMI of >35 with co-morbid conditions (such as degenerative joint disease, hypertension, hyperlipidemia, coronary artery disease, presence of other atherosclerotic diseases, Type II diabetes mellitus, sleep apnea and/or congestive heart failure).
- Bariatric surgery may be indicated for patients 18 to 60 years of age. Requests for bariatric surgery for patients less than 18 years of age should include documentation that the primary care physician has addressed the risk of surgery on future growth, the patient's maturity level and the patient's ability to understand the procedure and comply with post operative instructions, as well as the adequacy of family support. Patients above 60 years of age may be considered if it is documented in the medical record that the patient's physiologic age and co-morbid condition(s) result in a positive risk benefit ratio.
- The patient has been clinically evaluated by an M.D. or D.O. The physician has documented failure of non-surgical management including a structured, professionally supervised (physician or non-physician) weight loss program for a minimum of twelve consecutive months within the last four years prior to there commendation for bariatric surgery.

² http://www.ssa.gov/OP_Home/ssact/title18/1862.htm

- Documentation should include periodic weights, dietary therapy and physical exercise, as well as behavioral therapy, counseling and pharmacotherapy, as indicated.
- Documentation that the primary care physician and the patient have a good understanding of the risks involved and reasonable expectations that the patient will be compliant with all post-surgical requirements.
- A psychological evaluation must be performed as a pre-surgical assessment by a contracted mental health professional in order to establish the patient's emotional stability, ability to comprehend the risk of surgery and to give informed consent, and ability to cope with expected post-surgical lifestyle changes and limitations. Such psychological consultations may include one unit total of psychological testing for purposes of personality assessment (e.g., the MMPI-2 or adolescent version, the MMPI-A).
- In cases where a revision of the original procedure is planned, documentation of all of the following is required:
 - Date and type of previous procedure.
 - The factors that precipitated failure.
 - Any complications from the previous procedure that mandate (necessitate) the takedown.
 - If the indication for the revision is a failure of the patient to lose a desired amount of weight then the patient must meet all of the initial preoperative criteria.

Previous gastric restrictive procedures that have failed for anatomic or technical reasons (e.g., obstruction, staple dehiscence, etc.) are determined to be medically appropriate for revision without consideration of the initial preoperative criteria.

Conditions for Payment

BCBSM Medicare Advantage private fee-for-service plans use the Centers for Medicare & Medicaid Services deemed provider³ concept for group specific benefits. The table below specifies payment conditions for weight loss surgery:

Conditions For Payment	
Eligible providers	M.D., D.O., Practitioners
Deemed provider	See terms and conditions on bcbsm.com/ma
Payable locations	Inpatient hospital, outpatient hospital
Frequency	No restrictions

³ 2008 Terms and conditions

Conditions For Payment	
CPT/HCPCS codes ⁴	43842, S2083
Diagnosis restrictions	Must be billed with diagnosis code 278.01 (morbid obesity)
Age restrictions	18 years and older

Reimbursement

The maximum payment amount for the weight loss surgery benefit is available in a separate document, [BCBSM Medicare Advantage - Additional Benefits Fee Schedule](#).

The maximum payment amount for the additional weight loss surgery benefit is consistent with Original Medicare except for CPT/HCPCS codes 43842 and S2083.

The provider will be paid the lesser of this allowable amount or the provider's charge, minus the member's cost-share. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

Member Cost-sharing

- Deemed providers must agree to collect from the member only the cost-sharing amounts described in the table below. They may not otherwise charge or bill the member.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with the noncovered service.

The cost-sharing chart below identifies members with weight loss surgery coverage.

Member Cost-Sharing Responsibilities				
Group Name and Number	Annual Deductible	Coinsurance		Out-of-Pocket Maximum
		Professional Claim	Institutional Claim	
	2008	2008	2008	2008
State of Michigan Retirees 81820, 81821, 81828	\$200	None	SOB ⁵	Does not apply

⁴ State of Michigan Retirees Benefit grid

⁵ 2008 Summary of benefits

Billing Instructions

1. Bill services on the CMS 1500 (8/05) claim form, UB-04 or the 837 equivalent claim.
2. Use the Medicare Advantage private fee-for-service unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to your local BCBS plan.
6. Use electronic billing:
 - a. Michigan providers:
 - A copy of the ANSI ASC X12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (BCBSM Electronic Data Interchange (EDI) Institutional 837/835 Companion Document) is available at:
http://www.bcbsm.com/pdf/837_835_institutional_companion.pdf
 - A copy of the BCBSM EDI Professional 837/835 Companion Document is available at:
http://www.bcbsm.com/pdf/systems_resources_prof_837_835.pdf
 - b. Providers outside of Michigan should contact their local BCBS plan.