This document is only effective for claims with a date of service prior to Jan. 1, 2014.

Weight loss surgery

Applies to:

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

☐ Medicare Plus Blue℠ PPO ☒ Medicare Plus Blue℠ Group PPO ☐ Both

Weight loss surgery

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 web site at: **http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Bariatric-Surgery.html**

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.

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 Act 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 Plus Blue Group PPO

Medicare Plus Blue Group PPO plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows BCBSM to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for enhanced weight loss surgery benefits is provided to members under select Medicare Plus Blue Group PPO plans. This enhanced benefit paper applies to standard groups that selected this benefit. The member's cost–sharing and other covered conditions 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.
- 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.

Note: Effective January 1, 2014, BCBSM will no longer offer weight loss surgery as an enhanced benefit.

Conditions for payment

The table below specifies payment conditions for sweight loss surgery.

Conditions for payment	
Eligible provider	M.D., D.O., practitioners
Payable location	Inpatient hospital, outpatient hospital
Frequency	No restrictions
CPT/HCPCS codes	43842, S2083
Diagnosis restrictions	Must be billed with diagnosis code 278.01 (morbid obesity)
Age restrictions	18 years and older

Reimbursement

Medicare Plus Blue Group plan's maximum payment amount for the weight loss surgery benefit is available on our provider website, bcbsm.com/provider/ma in the MA enhanced benefits fee schedule. The provider will be paid the lesser of this allowed 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

- Medicare Plus Blue Group PPO providers should collect the applicable cost–sharing from the member at the time of the service when possible. Cost–sharing refers to a flat–dollar copayment, a percentage coinsurance or a deductible. You can only collect the appropriate Medicare Plus Blue Group PPO cost–sharing amounts from 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.

For detailed information about a Medicare Plus Blue Group PPO member's benefits and cost–share, providers may verify member benefits via web–DENIS or call CAREN at 1–866–309–1719.

Billing instructions for members

1. Bill services on the CMS 1500 (8/05) claim form, UB-04 or the 837 equivalent claim.
2. Use the Medicare Advantage PPO 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: ***bcbsm.com/pdf/837_835_institutional_companion.pdf***
      — A copy of the BCBSM EDI Professional 837/835 Companion Document is available at: ***bcbsm.com/pdf/systems_resources_prof_837_835.pdf***
   b. Providers outside of Michigan should contact their local BCBS plan.