

Effective: August 1, 2023

<p>Prior Authorization Required If <u>REQUIRED</u>, submit supporting clinical documentation pertinent to service request.</p>	<p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>
<p>Notification Required IF <u>REQUIRED</u>, concurrent review may apply</p>	<p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>

Applies to:

Commercial Products

- Harvard Pilgrim Health Care Commercial products; 800-232-0816
- Tufts Health Plan Commercial products; 617-972-9409
CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

- Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
- Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
- Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
- Tufts Health Unify* – OneCare Plan (a dual-eligible product); 857-304-6304
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

Senior Products

- Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
- Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
- Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Harvard Pilgrim Health Care Members:

This policy utilizes InterQual[®] criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Researched and the InterQual[®] link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the [instructions here](#)). Members may access materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742

For Tufts Health Plan Members:

To obtain InterQual[®] SmartSheets[™]

- **Tufts Health Plan Commercial Plan products:** If you are a registered Tufts Health Plan provider [click here](#) to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888.884.2404
- **Tufts Health Public Plans products:** InterQual[®] SmartSheet(s) available as part of the prior authorization

process

Tufts Health Plan requires the use of current InterQual® Smartsheet(s) to obtain prior authorization.

In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan

Overview

Harvard Pilgrim Health Care Commercial Products:

Harvard Pilgrim Health Care (HPHC) has designated selected in-network facilities as Weight Loss Surgery Centers of Excellence (COE); these facilities provide access to integrated programs focused on patient health, safety and cross-functional team support, and have met stringent quality criteria established by the American College of Surgeons and/or the American Society for Metabolic and Bariatric Surgery.

- A list of designated Weight Loss Surgery Centers of Excellence is published on HPHC's public website: <https://www.harvardpilgrim.org/public/find-a-provider>

To ensure quality of care, HMO members should be directed to a designated Weight Loss Surgery Center of Excellence.

- For POS and PPO members, medically necessary procedures performed at designated Centers of Excellence facilities are covered at in-network cost; procedures performed at non-COE facilities may be covered at out-of-network benefits levels.

Tufts Health Plan Commercial HMO and EPO Products:

Bariatric surgery must be performed at facilities in the [Designated Provider Network for Bariatric Surgery \(DPNBS\)](#) in order for the procedure to be covered for HMO and EPO Members.

Tufts Health Plan Commercial POS and PPO Products:

If POS and PPO Members want to receive coverage at the authorized/In-network level of benefits, bariatric surgery must be performed at one of the facilities in the [Designated Provider Network for Bariatric Surgery \(DPNBS\)](#). For POS/ PPO Members, if bariatric surgery is not performed at a DPNBS facility, coverage will be provided at the unauthorized/out of network level of benefits.

Tufts Health Plan Public Plan Products:

Bariatric surgery must be performed at facilities in the [Designated Provider Network for Bariatric Surgery \(DPNBS\)](#) in order for the procedure to be covered for Public Plan Members

Clinical Guideline Coverage Criteria

The Plan requires the use of InterQual® Subsets or SmartSheets for the following procedures:

- Revisional Procedure – Adult (Version 2022)
- Laparoscopic Adjustable Gastric Band (Repair, Revision) – Adult (Version 2022)
- Laparoscopic Adjustable Gastric Band (Removal) – Adult (Version 2022)
- Adjustment of Gastric Band Diameter – Adult (Version 2022)
- Biliopancreatic Diversion with Duodenal Switch – Adult (Version 2022)
- Roux-en-Y Gastric Bypass - Adult (Version 2022)
- Sleeve Gastrectomy - Adult (Version 2022)
- Laparoscopic Adjustable Gastric Band - Adult (Version 2022)

For this policy, The Plan draws upon the following InterQual® criteria:

- Roux-en-Y Gastric Bypass - Adolescent (Version 202)
- Sleeve Gastrectomy - Adolescent (Version 2022)
- Revisional Procedure – Adolescent (Version 2022)
- Laparoscopic Adjustable Gastric Band (Removal) – Adolescent (Version 2022)
- Laparoscopic Adjustable Gastric Band (Repair Revision) – Adolescent (Version 2022)

Limitations

The Plan considers the following procedures to be investigational and, therefore, not medically necessary:

- Intra-gastric balloon procedures for the treatment of obesity (e.g. Orbera Intra-gastric Balloon System, ReShape Integrated Dual Balloon System)

- 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
- Single anastomosis gastric bypass (also referred to as “mini gastric bypass”)
- TransPyloric Shuttle
- Bariatric Surgery, Adjustable Gastric Banding in Adolescents

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

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
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)
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 restrictive device (separate procedure)
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only
43999	Unlisted procedure, stomach

References:

1. Inge T, Courcoulas A, Jenkins T, et al. Weight loss and health status 3 years after bariatric surgery in adolescents. NEJM 2015; DOI: 10.1056/NEJMoa1506699 accessed December 17, 2015
2. Stefater MA, Jenkins T, Inge T. Bariatric surgery for adolescents. Pediatric Diabetes 2013; 14:1-12
3. Hayes, Inc. Roux-en-Y Gastric Bypass for Treatment of Type II Diabetes: A Review of Reviews. Hayes Medical Technology Directory. May 25, 2017. Accessed July 8, 2023.
4. Hayes, Inc. OverStitch Endoscopic Suturing System (Apollo Endosurgery Inc.) for Transoral Outlet Reduction: Hayes

Evolving Evidence Review. May 7, 2021. Last accessed July 8, 2023.

5. Hayes, Inc. Comparative Effectiveness Review of Bariatric Surgeries for Treatment of Obesity in Adolescents. Hayes Comparative Effectiveness Review. January 13, 2019. Last accessed July 8, 2023.
6. Mass Health. [MassHealth Guidelines for Medical Necessity Determination for Bariatric Surgery. MassHealth Guidelines for Medical Necessity Determination for Bariatric Surgery | Mass.gov. August 19, 2019.](#) Accessed July 8, 2023.

Approval And Revision History

February 16, 2022: Reviewed by Medical Policy Approval Committee (MPAC) for integration purposes between Harvard Pilgrim Health Care and Tufts Health Plan with an effective date of March 4, 2022. Retired medical policy for “Reoperation of Bariatric Operations”; content for reoperation included in this MNG and procedures now require review with IQ Smartsheets

Subsequent endorsement date(s) and changes made:

- November 16, 2022: Reviewed by MPAC; bariatric surgery must be performed at facilities in the Designated Provider Network to be covered for Public Plan Products, effective January 1, 2023.
- December 1, 2022: Reviewed by MPAC, renewed without changes
- June 21, 2023: Reviewed by MPAC, 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. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

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.