This is an update to an article that was posted on this website on January 9, 2008, titled, “Bariatric Surgery Benefits Now Available.” Effective for dates of service on or after July 1, 2008, bariatric surgery services will be benefits of Texas Medicaid (for clients 21 years of age and older) and the Texas Health Steps-Comprehensive Care Program (THSteps-CCP) (for clients birth through 20 years of age). Also, the previous article incorrectly stated that procedure code 2/8/F-43845 will be a benefit. Procedure code 2/8/F-43845 is not a benefit of Medicare and will not be a benefit of Texas Medicaid. Click on the title to view the details.

The following procedure codes may be reimbursed for bariatric surgery services with prior authorization:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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</thead>
<tbody>
<tr>
<td>2/8/F-43644</td>
</tr>
<tr>
<td>2/8/F-43771</td>
</tr>
<tr>
<td>2/8/F-43842</td>
</tr>
<tr>
<td>2/8/F-43848</td>
</tr>
</tbody>
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 Correction to previous article: Procedure code 2/8/F-43845 is not covered by Medicare and will not be made a benefit of Texas Medicaid.

The procedure code(s) in column B in the table below are denied when billed with the same date of service by the same provider as the procedure code in column A:

<table>
<thead>
<tr>
<th>Column A: Procedure Code to be Considered for Reimbursement</th>
<th>Column B: Procedure Code(s) to be Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/8/F-43645</td>
<td>2/8/F-43644</td>
</tr>
<tr>
<td>2/8/F-43770</td>
<td>2/8/F-43848</td>
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<tr>
<td>2/8/F-43771</td>
<td>2/8/F-43848</td>
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<td>2/8/F-43772</td>
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<tr>
<td>2/8/F-43773</td>
<td>2/8/F-43772, 2/8/F-43848</td>
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<tr>
<td>2/8/F-43774</td>
<td>2/8/F-43772, 2/8/F-43848, 2/8/F-43888</td>
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<tr>
<td>2/8/F-43842</td>
<td>2/8/F-43848</td>
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<tr>
<td>2/8/F-43843</td>
<td>2/8/F-43848</td>
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<td>2/8/F-43644, 43848</td>
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<tr>
<td>2/8/F-43847</td>
<td>2/8/F-43645, 2/8/F-43846, 2/8/F-43848</td>
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<tr>
<td>2/8/F-43888</td>
<td>2/8/F-43887</td>
</tr>
</tbody>
</table>

Bariatric surgery requests for prior authorization for Texas Medicaid clients birth through 20 years of age are considered on a case-by-case basis by THSteps-CCP with documentation of medical necessity. Prior authorization is a condition for
reimbursement; it is not a guarantee of payment. Providers may fax or mail prior authorization requests for bariatric surgery services for clients who are birth through 20 years of age to the TMHP Comprehensive Care Program (CCP) Department at:

Texas Medicaid & Healthcare Partnership
Comprehensive Care Program (CCP)
PO Box 200735
Austin, TX 78720-0735
Fax: 1-512-514-4212

Note: Providers may refer to the list of documentation requirements for clients 21 years of age and older to determine any other documentation that may be appropriate or necessary to include when requesting prior authorization for clients who are birth through 20 years of age.

For clients 21 years of age and older, bariatric surgery requests for prior authorization are considered when the information submitted documents all of the following:

- **A summary of the treatment provided for the client’s comorbid conditions and how the client’s response to standard treatment measures is unsatisfactory.** Prior authorization requests may be approved when bariatric surgery is medically necessary in order to treat medical conditions that are caused or significantly worsened by the client’s obesity and the comorbid conditions cannot be adequately treated by standard measures unless significant weight reduction takes place. The severe nature of the conditions must be such that medical necessity is clear when taking into account the risks of the surgery.

- **The patient has demonstrated compliance with a physician-directed nonsurgical weight loss program.** Documentation from the client’s physician must indicate at least 12 months of compliance with a physician-directed, nonsurgical weight loss program within 18 months of the request date.

- **The surgery is medically necessary.** The documentation must contain a description of why the bariatric surgery is medically necessary in the context of current treatment and the medically reasonable alternatives that are available. Bariatric surgery is considered to be medically necessary when the prior authorization request documents either of the following:

  - The client has a body mass index (BMI) greater than or equal to 35 kg/m² and at least one of the following conditions:
    - Obesity-associated hypoventilation.
    - Obstructive sleep apnea.
    - Congestive heart failure.
    - Hypertension with inadequate control.
    - Pulmonary hypertension.
    - Accelerated weight-bearing joint disease.
    - Gastroesophageal reflux disease with aspiration.

  - The client’s BMI is greater than or equal to 35 kg/m² and at least two of the following conditions:
    - Adult onset (Type II) diabetes (with or without complications).
    - Cardiovascular or peripheral vascular disease.
    - Lipid or cholesterol metabolism disorder.
    - Chronic skin ulceration.
No significant contraindications exist. Documentation provided for prior authorization must attest that no significant contraindications are present, including the following:

- Perioperative risk of cardiac complications.
- Poor myocardial reserve.
- Significant chronic obstructive airway disease or respiratory dysfunction.
- Significant eating disorders.
- Psychological disorders of a significant degree that a psychologist or psychiatrist anticipates could be exacerbated or interfere with the long-term management of the client after the operation.

Note: Clients with known serious mental illness should be assessed prior to surgery to ascertain whether their illness is a contraindication to surgery. Clients should be referred for appropriate professional evaluation any time the presence of serious mental illness is suspected.

The name of the facility in which the procedure will be performed. The facility must be recognized as a Bariatric Surgery Center of Excellence® (BSCOE) by the Centers for Medicare & Medicaid Services (CMS) as certified by the American Society for Metabolic and Bariatric Surgery or recognized by CMS as a Level One Bariatric Surgery Center as designated by the American College of Surgeons.

Prior authorization is a condition for reimbursement; it is not a guarantee of payment. Providers may fax or mail prior authorization requests for clients 21 years of age and older to the TMHP Special Medical Prior Authorization Department at:

Texas Medicaid & Healthcare Partnership
TMHP Special Medical Prior Authorization Department
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: (512) 514-4213

Repeat bariatric surgery may be considered medically necessary in either of the following circumstances:

- To correct complications from bariatric surgery such as band malfunction, obstruction, or stricture.
- To convert to a Roux-en-Y gastroenterostomy or to correct pouch failure in an otherwise compliant client when the initial bariatric surgery met medical necessity criteria.

Note: Conversion to a Roux-en-Y gastroenterostomy may be considered medically necessary for clients who have not had adequate success (defined as a loss of more than 50 percent of excess body weight) two years following the primary bariatric surgery procedure, and the client has been compliant with a prescribed nutrition and exercise program following the procedure.
Bariatric surgery is not a benefit when the primary purpose of the surgery is any of the following:

- For weight loss for its own sake.
- For cosmetic purposes.
- For reasons of psychological dissatisfaction with personal body image.
- For the client's or provider's convenience or preference.

Behavioral health services provided as part of the preoperative or postoperative phase of bariatric surgery are subject to behavioral health guidelines and are not considered part of the bariatric surgery. For information about behavioral health services, providers may refer to the 2008 *Texas Medicaid Provider Procedures Manual*, Section 36.4.39, “Psychiatric Services,” on page 36-109.

Reimbursement rates for bariatric surgery procedure codes will be assigned after the rate hearing scheduled to be held on June 1, 2008. Providers will be informed of the adopted rates in a future banner message.

For additional information, call the TMHP Contact Center at 1-800-925-9126.