Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Bariatric Surgery Precertification Review

Date: ________________ Reference #: ______________________________(provided after initial review)

A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call HealthLink at 1-877-284-0102.

Provider Information

Provider Name: ____

Address: ____

Phone: _____________________________

Fax: _______________________________

Patient Information

Patient Name: ____

ID Number: _________________________

Address: ____

Patient's DOB: _______________________

Phone: _____________________________

Ordering Physician Information

Ordering Physician Name: ____

Address: ____

Phone: _____________________________

Fax: _______________________________

TIN: _______________________________

Treatment Information

Is patient being treated? ☐ Outpatient ☐ Inpatient

If inpatient, anticipated length of stay: ____________________

Primary Procedure: ____

Procedure (ICD-10) Code(s): __________________________

Date of Procedure: ____________________

Place of Service: ____

Please check the procedure from the list below:

☐ Gastric bypass with a Roux-en-Y procedure up to 150 cm

☐ Laparoscopic adjustable gastric banding (e.g. Lap-Band System® or REALIZE™ Adjustable Gastric Band)

☐ Vertical banded gastroplasty

☐ Biliopancreatic bypass with duodenal switch

☐ Sleeve gastrectomy (open or laparoscopic)

☐ Revision of a gastric restrictive procedure

☐ Gastric bypass using a Billroth II type of anastomosis, also known as a “mini gastric bypass”

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.

☐ Malabsorptive procedures including, but not limited to, jejunoileal bypass, biliopancreatic bypass without duodenal switch, or very long limb (>150 cm) gastric bypass (other than biliopancreatic bypass with duodenal switch)

☐ Other surgical gastric bypass/restrictive procedures not listed above including, but not limited to, minimally invasive endoluminal gastric restrictive surgical techniques, such as the EndoGastric StomaphyX™ endoluminal fastener and delivery system.

☐ Other: ______________________________

The patient has the following condition(s):

Patient's height, weight and BMI fields must be provided for all requests:

Patient's Height:_________ ☐in ☐ cm

Patient's Weight: _______________ ☐lbs ☐kg

Patient's BMI: __________________

☐ Patient is 18 years of age or older

☐ BMI of 40 or greater

☐ BMI of 35 or greater with obesity-related co-morbid condition: (check all that apply)

- ☐ Life-threatening cardio-pulmonary problems (check all that apply)
  - ☐ Severe sleep apnea
  - ☐ Obesity related cardiomyopathy
  - ☐ Pickwickian syndrome
  - ☐ Other: ______________________
- ☐ Diabetes mellitus
- ☐ Cardiovascular disease
- ☐ Hypertension
- ☐ Other: ______________________________

☐ Other Condition(s): ____

____

Please check which of the following have occurred prior to a decision to proceed with surgical intervention:

☐ Patient has actively participated in non-surgical methods of weight reduction and the efforts have been fully appraised by the physician requesting authorization for the surgery

Please list methods and dates of participation (start/end dates) ___________________________________

____

____

☐ The physician requesting authorization for the surgery has confirmed the:

- ☐ Patient's psychiatric profile is such that the member is able to understand, tolerate and comply with all phases of care and is committed to long-term follow-up requirements
- ☐ Patient's post-operative expectations have been addressed
- ☐ Patient has undergone a preoperative medical consultation and is felt to be an acceptable surgical candidate
- ☐ Patient has undergone a preoperative mental health assessment and is felt to be an acceptable candidate
- ☐ Patient has received a thorough explanation of the risks, benefits and uncertainties of the procedure
- ☐ Patient's treatment plan includes pre- and post-operative dietary evaluations and nutritional counseling

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☐ Patient's treatment plan includes counseling regarding exercise, psychological issues and the availability of supportive resources when needed

☐ Request is for repeat surgical procedure for revision or conversion to another surgical procedure for inadequate weight loss (please check applicable patient conditions above and below)

☐ There is documentation of patient's compliance with the previously prescribed postoperative dietary and exercise program

☐ 2 years following the original surgery, weight loss* is less than 50% of pre-operative excess body weight and weight remains at least 30% over ideal body weight (taken from standard tables for adult weight ranges based on height, body frame, gender and age).

Date of original surgery: ________________

Height: _________

Weight prior to original surgery: ___________

Current weight: __________

☐ Request is for adjustment to band device following initial adjustable banding procedure: (check all that apply)

☐ To control rate of weight loss

☐ To treat symptoms secondary to gastric restriction; please describe: ______________________________

☐ Other: ____

☐ Other:____

Repair or Repeat Procedure:

☐ Request is for surgical repair and there is documentation of a surgical complication related to the original procedure (Please complete below):

☐ Fistula

☐ Obstruction

☐ Erosion

☐ Pouch enlargement due to vomiting

☐ Stretching of the stomach pouch due to patient's overeating

☐ Other: ___________________________________

☐ Disruption/leakage of suture/staple line

☐ Band herniation

For Indiana members please complete the following:

☐ The patient's obesity has persisted for at least 5 years

☐ Patient has tried physician supervised non-surgical treatment for at least 6 consecutive months

☐ Patient is 21 years of age or older

Provider Contact Information

Contact Person: ____

Title: ________________________________

Phone: ______________________________

Fax: ________________________________

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