



IEHP UM Subcommittee Approved Authorization Guideline			
<b>Guideline</b>	Adolescent Bariatric Consultation and Surgery	<b>Guideline #</b>	UM_SUR 09
		<b>Original Effective Date</b>	2/14/2018
<b>Section</b>	Surgery	<b>Revision Date</b>	05/12/2021

### COVERAGE POLICY

IEHP considers bariatric surgery for adolescent Members to be medically necessary for specific indications. For Members over the age of 17, please refer to Medi-Cal Provider Manual-Surgery: Digestive System.

I. IEHP considers adolescent bariatric surgery to be medically necessary if the following criteria are met:

- A. The Member has attained adequate physical and mental maturity as confirmed by the Member's primary care provider (Alqahtani, 2014, Spear, 2007; Inge, 2004).  
Generally, this means that the adolescent Member is able to provide assent for surgery.
- B. The adolescent Member has documented clinically severe obesity which is defined for adolescents as:

1. BMI  $\geq$ 120% of the gender-specific 95<sup>th</sup> percentile on the CDC BMI- for-age growth chart (Weiss, 2017) and two comorbidities as listed below
  - a. Diabetes Mellitus, Type II (Hsia, 2012; Inge, 2004)
  - b. Obstructive sleep apnea with an Apnea-Hypopnea Index (AHI) of >15 or obesity hypoventilation syndrome (Hsia, 2012)
  - c. Intracranial hypertension (formerly Pseudotumor cerebri) (Hsia, 2012)
  - d. Non-alcoholic fatty liver disease or non-alcoholic steatohepatitis (NASH)
  - e. Hypertension or dyslipidemia requiring medication
  - f. Impaired quality of life or psychosocial stress and one other comorbidity as listed in I.B.1.a-h
  - g. Weight-related arthropathies
  - h. Slipped Capital Femoral Epiphysis (SCFE) or Blounts syndrome

OR

2. BMI  $\geq$ 140% of the gender- specific 95<sup>th</sup> percentile on the CDC BMI- for-age growth chart (Weiss, 2017) and one comorbidity (see item I.B.1. a-h above)
- C. The Member has actively participated in a formal six (6) consecutive month weight loss program with monthly visits to the Primary Care Provider for supervision (Spear, 2007; Inge 2004).
  - D. Member must be capable of and willing to adhere to nutritional guidelines and be able to demonstrate decisional capacity (Spear, 2007).
  - E. Consideration will be given for children with developmental delay or behavioral health diagnoses for whom surgery is considered medically necessary. Discussion with an accredited adolescent bariatric surgery center and the Medical Director is required for approval in these cases.
  - F. The Member must undergo a multidisciplinary evaluation with the following specialists

(Inge, 2004):

1. Pediatric Endocrinology or Pediatric Obesity Specialist
2. Psychiatry or Psychology
3. Bariatric Surgery Consultation with a Pediatric Bariatric Surgeon
4. Registered Dietitian with expertise in bariatric surgery

II. Revision of adolescent bariatric surgeries will be considered medically necessary when all of the following criteria are met:

- A. The initial bariatric surgery met criteria for medically necessary bariatric surgery
- B. The primary surgery failed secondary to significant post-operative complications
  1. Erosion, slippage, severe malnutrition, stricture or anastomotic complications
  2. Gastroesophageal reflux, or failure to lose weight or weight re-gain after a band or sleeve procedure
- C. The Member has been compliant with all post-operative instructions regarding nutritional intake, portion control and dietary restrictions

### **COVERAGE LIMITATIONS AND EXCLUSIONS**

- A. Members are considered ineligible for bariatric surgery if any of the following apply:
  1. Obesity attributed to other disease states or weight promoting medication; and/or
  2. Poorly controlled, severe behavioral health diagnosis that limits the Member's ability to comply with nutrition requirements and exercise regimens. Behavioral health diagnoses that are well controlled and in remission are considered on a case-by-case basis.
  3. Current substance use, abuse or disorder of alcohol and related substances or illicit substances; and/or
  4. Severe cardiomyopathy, end stage renal disease, or end stage liver disease unless surgery is required prior to transplant surgery; and/or
  5. Members with an unacceptable surgical risk – higher than normal risk for significantly adverse outcome as determined by the Pediatric Bariatric Surgery team.
- B. Adjustable gastric banding is not FDA approved for adolescents <18 year of age. (Weiss, 2017).

### **ADDITIONAL INFORMATION**

- A. Consideration may be given to the Member's support system preoperatively and postoperatively. Support systems include, but are not necessarily limited to, parents, grandparents, other family members, caregivers, teachers, counselors, therapists or clergy that will assist the Member in compliance with the postoperative bariatric diet and exercise plan.
- B. Although pregnancies can be safely supported after bariatric surgery, reliable contraception is recommended because of the increased risk to the fetus posed by the rapid weight loss in the immediate post-operative period. After the period of rapid weight loss, pregnancies should be carefully monitored. (Inge, 2004 ACOG, 2009)

### **CLINICAL/REGULATORY RESOURCE**

The safety and efficacy of pediatric and adolescent bariatric surgery has been established to be equal to that of adults in several significant prospective observational and retrospective meta-analyses (Black, 2013; Paulus 2015; Inge 2017). In addition, there is increasing evidence to support its use according to the American Society for Metabolic and Bariatric Surgery and the

American Academy of Pediatrics. Adolescent bariatric surgery can be considered medically necessary when criteria for adolescents is met.

## DEFINITION OF TERMS

- A. **BMI:** body mass index, calculated as weight in kilograms (kg) divided by height in meters squared ( $m^2$ ) –  $kg/m^2$
- B. **Revision:** surgical procedure performed to reverse a previous bypass or restrictive procedure or to anatomically convert a previous bypass surgery or restrictive procedure to an alternate procedure (e.g., adjustable gastric banding conversion to a conventional Roux-en-Y procedure)
- C. **Types of Bariatric Surgery**  
A review of the current data indicates that patient safety and weight loss outcomes for extremely obese adolescents undergoing bariatric surgery are comparable or better than those seen in adults (ASMBS, 2011). The most widely performed procedures in adolescents are:
1. Sleeve gastrectomy
  2. Roux-en-Y gastric bypass

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