

How to Discuss the Case with Insurance Plan Medical Director, Letter of Medical Necessity, and Increasing the Chance of Approval of Revision Operations

Letters of Medical Necessity are a well-known requirement when requesting authorization to perform bariatric operations. Requests for authorization for reoperative bariatric surgery must be well thought out and reflect a complete understanding of the plans benefits and definitions of what requirements each patient must meet in order to qualify to undergo a reoperative bariatric procedure. Many plans will have specific sections that outline which specific criteria must be met in order to qualify for a bariatric reoperation. Just asking if a medical plan includes benefits for reoperative bariatric operations is not enough to ensure success. It is increasingly common that in cases of recurrent obesity, a revision of a stapled bariatric operation such as sleeve gastrectomy or gastric bypass is going to require some sort of mechanical problem or defined complication which then resulted in insufficient weight loss. In addition, plans will require documentation as to exactly what the problem or complication is and how it resulted in the recurrent obesity. Simply stating that the operation “didn’t work” is unlikely to result in approval.

It is essential to read through the precertification requirements in the health plan documents to determine exactly what information you need to include in the letter of medical necessity. This information should be provided in coherent manner and take a prominent role in the LOMN. Most reoperative bariatric procedures are performed for recurrent or persistent obesity or to address a complication which has occurred as a result of the bariatric operation. Reoperative bariatric procedures will typically fall into one of the following categories:

- Removal of a lap band and revision to an alternative bariatric procedure in one procedure.
- Removal of a lap band and revision to an alternative bariatric procedure in two operations.
- Modification or removal of a lap band due to some failure of a lap band (erosion, slippage, esophageal dilation, dysphagia, chronic regurgitation, etc.)
- Modification or conversion of sleeve gastrectomy for recurrent obesity, GERD, obstruction, etc.
- Modification of a gastric bypass or other malabsorptive procedure due to some failure of the operation resulting in weight regain, dumping syndrome, malnutrition or other complication which can be addressed with a reoperation.
- Reversal of procedures - These are typically due to either malnutrition or some significant complication such as perforated ulcers, chronic dysphagia, or some other defined intolerance of the operation.

When faced with having to generate a letter of medical necessity (LOMN) preparation and understanding of the plan benefits is the key to success. Developing a strategy to achieve success with the request for authorization begins with understanding the following.

1. Identify a patient's eligibility

A. Exclusions of bariatric surgery

Immediately after evaluating a patient for a reoperative procedure you must determine if there are any exclusions for bariatric surgery in that particular patient's benefits of coverage. If there are no benefits for bariatric surgery there is little chance that the plan will allow a reoperation to an alternative procedure especially if the indication for the reoperation is persistent or recurrent obesity. Medical directors generally cannot approve a reoperation that involves conversions to another bariatric procedure when there is a contractual exclusion. It is not only important to prepare a patient for this reality but also for the possibility that the plan will not cover any desire to revise the original operation to a different procedure (lap band to sleeve gastrectomy etc.). Rather than waste your time trying to justify why your patient meets all national criteria to undergo the reoperation you have planned, it is better to discuss this reality with the patient as early in the evaluation process as possible. Understanding that there are no plan benefits for a primary bariatric operation is important not only to explain to the patient but allow you to focus on those items that *might* be covered. Many plans which exclude primary bariatric operations will allow surgical treatment of well-defined complications that occur as a result of previous bariatric operations.

- I. For example, if the goal is to revise a lap band that has endured a prolapse, then focusing on the prolapse and the resulting complications of the prolapse, GERD, dysphagia, regurgitation can often result in an authorization to treat the complication. This is especially true if the goal is not to remove the lap band but to treat the complication.
- II. Another clinical example might involve wanting to remove a lap band due to chronic dysphagia and esophageal dilation. This kind of complication might get approved by requesting removal secondary to diagnosis codes reflecting the dysphagia, reflux and esophageal dilation that the patient presents with. In cases where it can be documented that there is a hiatal hernia with associated reflux the plan might allow removal of the lap band to address these complications. By specifically addressing the complication that needs to be treated rather than the desire to perform a revision operation might increase the chance of approval for at least some of the procedure that needs to be performed when doing a revision procedure.
- III. Similarly revision of a gastric bypass with a large dilated gastrojejunostomy might be authorized if the focus in the LOMN is towards the diagnosis of dumping syndrome and the planned procedure is revision of a gastrojejunostomy. Although some policies exclude reoperative surgery for recurrent obesity, these same policies may cover reoperative surgery that addresses common anatomical or physiological complications following bariatric surgery.

In plans that have a clear exclusion of bariatric surgery, use the LOMN to carefully shift the attention away from the bariatric operation the patient has already undergone. Avoiding discussing any previous bariatric surgery can often result in an approval if the goal is to treat a complication which was the result of a previous bariatric operation. All too often a Letter of Medical Necessity will begin with a description of the patient such as:

“Mrs. Jones is a 45 year old woman who in 1995 underwent Roux en Y gastric bypass”

In cases where there is an exclusion of bariatric surgery this type of opening sentence will draw direct attention to the very item that the plan seems to exclude. A better strategy is to draw attention to the complication you want to address by avoiding the direct reference to the history of Roux en Y gastric bypass.

“Mrs. Jones is a 45 year old woman who presents with severe dumping syndrome and post prandial blood sugars dropping as low as 45....She has undergone previous gastrojejunostomy in 1995 and presents now with rapid gastric emptying which is amenable to revision of the gastrojejunostomy. Endoscopic examination reveals that the anastomosis is dilated to greater than 2 cm and is contributing to the rapid gastric emptying...authorization is requested to perform revision of the gastrojejunostomy with possible gastric resection and possible small bowel resection...”

When faced with a direct exclusion of bariatric procedures it can be extremely difficult, if not impossible, to obtain an authorization for a reoperation, especially if there is really nothing wrong with the previous bariatric operation.

B. Identify exactly what is wrong with the original bariatric operation that you want to revise

In putting together your letter of medical necessity, opening up that letter with a description of exactly what is wrong with the previous bariatric operation is essential to increasing the likelihood of a successful request for authorization. This is particularly true with conversion of lap band operation to different bariatric procedures. Many insurance providers will not give an authorization for removal of a lap band and conversion to a sleeve gastrectomy or other stapled procedure if there is not some primary problem with the lap band itself. For example, if there is nothing wrong with the lap band, prolapse, esophageal dilation, chronic dysphagia, etc., many medical directors will deny authorization of removal of a band and conversion to a stapled bariatric procedure. If the justification for the reoperation is persistent obesity due to the lap band, you can expect multiple denials unless you begin the process by describing what is wrong with the lap band and why the lap band needs to be

removed. It is better to focus on what the problem with the lap band is rather than the desire for better weight loss.

“Mrs. Jones presents with a two year history of progressive dysphagia resulting in multiple attempts at removing fluid and replacing fluid in her lap band. Despite multiple attempts at removing and adjusting fluid from the lap band she continues to have persistent dysphagia to solids. The lap band can no longer be adjusted and is essentially useless at this point as a weight loss device. Because of the persistent dysphagia the patient has had to leave the lap band empty. The dysphagia occurs despite no evidence of esophageal dilation and has prevented the further adjustment of the lap band as would be necessary to achieve weight loss with this device. This patient is intolerant of the lap band and it cannot be used as a weight loss device due to the inability to tolerate adjustments. She is currently unable to consume solid foods....”

By identifying and focusing on a clinical problem, rather than persistent obesity, the likelihood of a successful request for authorization in the letter of medical necessity will go up. Listing diagnosis codes such as dysphagia, reflux, regurgitation and pain, rather than morbid obesity alone, will increase the likelihood that an authorization will be approved. In many plans, identifying a primary problem with the original operation increases the likelihood that a reoperation to an alternative bariatric operation will be approved as a single stage operation. This is especially true if the patient meets the criteria to undergo a primary bariatric operation under the plan’s benefits.

C. Two stage bariatric reoperations; removing bands and reversing bariatric operations

Understanding the plan benefits with respect to who qualifies for a bariatric operation is important if the clinical plan you are recommending involves a two stage operation. Typically this will occur if you are trying to remove a lap band and want to come back at a later date and to perform a stapled operation, or if you want to reverse a stapled bariatric operation and then want to come back and revise to a different bariatric operation (bypass to sleeve, bypass to DS).

The surgeon should not assume that because you obtained an authorization to remove a lap band for an erosion or reverse a gastric bypass for severe dumping syndrome that you will be allowed to perform the secondary procedure at a later date. Many of the plans will by default consider your patient as if they have never had bariatric surgery before when requesting the second stage of your plan. You should be prepared that this may occur and prepare your patient for this by reviewing with them the importance of completing the necessary requirements.

- I. Patient has a BMI > 35 with comorbidities or >40 without comorbidities.** Identify all the plan requirements necessary to obtain authorization as a primary bariatric operation and begin the process of completing those requirements as if the patient had no prior bariatric surgery. Dietary consult, psychological consult, and documented history of medically supervised weight management are common requirements. Completing these requirements during the time in between the first stage and planned second stage of the revision will increase the likelihood of successful approval. When composing your letter of medical necessity specifically identify each and every requirement that was completed, and provide the documentation supporting the completion of those requirements in the very beginning of the letter of medical necessity. Your letter should almost appear as a bullet list of all the requirements completed, verbatim as to how they were listed in the plans benefit requirements. The LOMN should easily demonstrate the importance of this procedure to the patient's current health status regardless of the patient's past surgical history.
- II. Patient has a BMI 35-40 without comorbidities or <35 and does not clearly meet plan criteria for a bariatric operation.** At the outset, patients in this position should understand that the indication for surgery is not clearly covered and there is a potential for a prolonged authorization process with a lower likelihood for ultimate approval. This situation is much more difficult and typically requires a peer to peer discussion at the time of the initial request for authorization. Peer to peer discussions in this situation are an opportunity to have information entered into the patient's insurance company records at the level of the medical director, which can allow an authorization for the second stage to occur more smoothly at a later date. It is also a situation where requesting authorization in the letter of medical necessity for both stages, specifically stating that the second stage will be performed at a later date, 30, 60, 90 days later, might decrease the chances that the request for the authorization of the second stage might be denied. It is sometimes important to include the history of the patient's previous weight at the time when the original bariatric procedure was performed and any supporting medical records which verify the original BMI. These types of two stage procedures are often very difficult to get approved and often result in a lengthy process of appeals, peer to peer discussions, and outside appeals.

For example, a patient presents with a prolapse of the lap band but wants to have the lap band replaced at a second operation. Taking the time to request for a removal and replacement of the lap band and discussing the plan with the medical director to insure that the plan will approve the replacement of the band as a second operation is important to pursue prior to the initial removal of the lap band.

It is also important to prepare your patient for the reality that despite what the medical director might say at the time of the original authorization these low BMI patients are often very difficult to get authorized for a second stage, despite the best documentation provided.

D. Weight gain during the required three - six month medically supervised weight management program

Many insurance plans have started to deny patients who present with weight gain during a required 3 – 6 month medically supervised weight management program. Expect that more and more plans will start denying patients who gain as little as 2 pounds during these required periods. The best strategy is to inform your patients that any weight gain can result in a denial. Encourage them to come in frequently to weigh and document those weights in their medical record. The more weights you have the more arguments you can present to the medical director that small fluctuations were not the trend, and that the overall weight either stayed the same, or resulted in some weight loss during the six month medically supervised weight management period. Except for very minor fluctuations that could result during monthly menstrual cycles, it is very difficult to overcome a “no weight gain” requirement should your patient gain any weight during the 3-6 months reported to the insurance company. Small fluctuations such as a two pound weight gain should be addressed with another weight check within a week from the small weight gain and the patient should be counseled that these fluctuations could result in a denial.

Many medical conditions and medications can be associated with weight gain. If the patient is started on a new medication or is diagnosed with a new condition that is associated with weight gain or fluid retention complete documentation from the provider prescribing the new medication or managing the diagnosis can be helpful in discussing weight gain with a medical director.

It is best to make each patient very much aware of this “no weight gain” possibility and assume such a provision is in place. Including a series of weights done at your office in the letter of medical necessity that demonstrates progressive weight loss and no overall weight gain during the required time period will also increase the chance of an approval for the second stage of a revision operation.

E. Recurrent obesity after stapled procedures

Gastric bypass, Gastric Sleeve, or BPD patients who have recurrent obesity with a BMI exceeding 40 and an “intact” operative anatomy in place are a clinical challenge. The clinical plan you want to implement will influence the direction that you take with your letter of medical necessity. Shortening a common channel, placing a band over a gastric bypass or gastric sleeve, decreasing the size of what appears to be a dilated gastric pouch or gastric

sleeve all require letters of medical necessity that focus on why the patient needs that specific therapy. Modification of a common channel might require an argument that the previous common channel was made too long and there was not enough malabsorption created at the time of the original operation.

Decreasing the size of a dilated gastric pouch/sleeve might imply to the medical director that the patient is non-compliant. Taking the time to demonstrate that the patient is adherent to dietary recommendations, food diaries, etc. will increase the chance that a pouch reduction procedure might be approved. In addition, it is helpful to explain that some dilation of the procedure is the natural history of stapled operations regardless of eating habits. Including the results of the preoperative EGD that includes anatomic landmarks like a retained fundus and an intact Angle of His strengthens your argument that the initial operation was performed with a large gastric pouch. In all these scenarios specifically avoiding describing the patient as an individual who has “failed” a gastric bypass will increase the chance that the authorization will be obtained rather than having the request denied based on presumed non-compliance on the part of the patient. In the case that a peer to peer discussion is necessary taking the time to document all your arguments will increase the chance that the reviewer might authorize the procedure.

F. What to do if your LOMN results in a denial

Despite some of the best letters of medical necessity denials are inevitable. In the event of a denial the resulting letter issued by the insurance company will usually outline the specific reason for the denial and as a result tell you exactly what the patient’s options are to address and/or challenge the denial. The letter of denial will either make it clear that your patient does not meet the criteria under the plan’s benefits of coverage or will tell you what deficiencies need to be addressed in order to obtain an authorization. Peer to peer discussions with the medical director can often overturn a denial if the reasons for the denial can or have been met. Peer to peer discussions can also give you the opportunity to present the specifics of why this patient should be an exception to the denial. In cases where the desire is to remove the lap band and revise to a sleeve gastrectomy or other stapled operation in one stage the peer to peer discussion will often make it clear that the plan will only authorize a removal of the lap band but not a revision to another procedure. In these situations it is best to simply remove the band and then resubmit the patient as a patient requesting a primary stapled operation at a later date, being sure to address the completion of all plan requirements when changing from a one stage operation to a two stage operation.

2. Summary

In summary, when requesting authorization for a reoperation of a bariatric procedure be sure you have reviewed the patients insurance plan benefits thoroughly, and that you have specifically reviewed the requirements to receive benefits for reoperative bariatric surgery. Unless your letter of medical necessity includes and addresses each

of the provisions outlined under the plan benefits for reoperative bariatric surgery a denial of authorization is going to be the most likely outcome. The pathway to a successful reoperation of a bariatric procedure might involve one stage or multiple stages and could involve three or six months of follow-up appointments, weight recording, dietitian follow-up, and support group meetings. Documentation of all of the requirements completed and presentation of successful completion of all of the requirements outlined in the benefits of coverage for reoperative bariatric surgery when forming a letter of medical necessity is the most successful way to obtain an authorization for the planned procedure. Preparing your patient in advance for the likelihood of a lengthy process is the best way to keep your patient motivated and optimistic. Either way, a thorough understanding of the patient's benefits of coverage is required to obtain a successful outcome.