Bariatric Surgery (Medical Policy IV-19)
Commercial Pre-authorization (PA) Request Form

BlueCross BlueShield Minnesota

Please refer to medical policy criteria on providers.bluecrossmn.com for clinical review criteria prior to submission.

Effective May 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) providers are required to use the Availity® Provider Portal to submit preservice prior authorization requests. **Faxes and phone calls for these requests will no longer be accepted by Blue Cross.** Please complete the clinical sections on this form and attach it to your request at **availity.com** to ensure a timely review.

Providers outside of Minnesota without electronic access can fax this form, along with clinical records to support the request, to (651) 662-2810.

Patient Information

Will waiting the standard review time seriously jeopardize the life or health of the member or the member's ability to regain maximum function? ☐ **Yes** ☐ **No**

Member ID: _____ _____ Group number: _____

Member name: _____ Date of birth: ___ /___ /_____

Member address: _____

Member city/state/ZIP: _____

Member phone: ____-____-_____

Servicing Provider Information

Contact person: _____ Phone: ____-____-_____

Servicing provider name: _____

Servicing provider ID/NPI number: _____

Servicing provider address: _____

City/state/ZIP: _____

Servicing provider phone: ____-____-_____ Servicing provider fax: ____-____-_____

Inpatient/outpatient facility name: _____ Facility ID:_____

Blue Distinction® Center (BDC) for Bariatric Surgery? ☐ No ☐ BDC ☐ BDC+

Ordering Provider Information

Ordering provider name: _____

Ordering provider ID/NPI number: _____

Ordering provider address: _____

City/state/ZIP: _____

Ordering provider phone: _____-_____-_____ Ordering provider fax: _____-_____-_____

Services/Procedures/Items Requested

HCPC/CPT Code(s)	HCPC/CPT Code(s) Description	ICD-10 Diagnosis Code(s)	Start Date mm/dd/yy	End Date mm/dd/yy

Member ID: _____ _____

Please attach all relevant clinical documentation that supports information selected in the form.

Surgical Procedure

Surgical Procedure (e.g., open or laparoscopic Roux-en-Y, adjustable gastric banding, open or laparoscopic sleeve gastrectomy, open or laparoscopic biliopancreatic diversion with duodenal switch):

Is this a revision or conversion surgery? ☐ **Yes** ☐ **No**

If, yes, date of original surgery: ___ /___ /_____

If, yes, please supply the specific indication for revision/conversion surgery (choose one):

☐ Treatment of surgical complications or technical failures following the original bariatric surgery (please describe):

☐ Inadequate weight loss following the original surgery (please provide documentation of patient compliance with post-surgical care plan and psychological evaluation for reoperation)

Member ID: _____ _____

Patient Selection Criteria

Body mass index (BMI): _____ Date of measurements: ___ /___ /_____

Height: _____(feet) _____(inches)

Weight: _____ ☐ lbs ☐ kg

AND

One of the following:

☐ Age 18 years or older

OR

☐ Bone age of ≥ 13 years in girls or ≥ 15 years in boys; OR attainment of 95% of adult height based on estimates of bone age

AND

☐ BMI: ≥ 40 kg/m^2

OR

☐ BMI 35 to <40 kg/m^2 (please check all that apply):

- ☐ Hypertension refractory to standard treatment
- ☐ Cardiovascular disease
- ☐ Type 2 diabetes mellitus
- ☐ Obstructive sleep apnea (OSA) requiring continuous positive airway pressure (CPAP) or other related treatment
- ☐ Obesity hypoventilation syndrome (OHS)
- ☐ Pickwickian syndrome (a combination of OSA and OHS)
- ☐ Nonalcoholic fatty liver disease (NAFLD)
- ☐ Nonalcoholic steatohepatitis (NASH)
- ☐ Pseudotumor cerebri

OR

☐ BMI: 30 kg/m^2 – 34.9 kg/m^2 with type 2 diabetes mellitus, with inadequate glycemic control (HbA1c ≥8%)

AND

☐ Patient is a never-smoker OR has abstained from smoking, use of smokeless tobacco and/or nicotine products, and/or nicotine replacement therapy for a minimum of 6 weeks prior to surgery.

AND

All of the following:

☐ Psychological evaluation was completed: Date: ___ /___ /_____
by _____ (provider name and credentials)

☐ Verification of patient participation in preoperative program: Date: ___ /___ /_____
by _____ (provider name and credentials)

☐ Completion of surgical preparatory program: Date: ___ /___ /_____
by _____(provider name and credentials)

Member ID: _____ _____

Description/Additional Information:

Total pages: _____