



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

GASTRIC BYPASS SURGERY PRIOR AUTHORIZATION REQUEST

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: _____ **RECIPIENT MEDICAID ID:** _____

RECIPIENT HEIGHT: _____ **RECIPIENT WEIGHT:** _____

DOES RECIPIENT HAVE ALTERNATE INSURANCE PLAN? YES NO

NAME OF INSURANCE PLAN: _____

DIAGNOSIS: _____ **ICD-9:** _____ **CPT:** _____

PROVIDER INFORMATION

DATE OF REQUEST: ____/____/____ **CONTACT PERSON #:** _____

PROVIDER NAME: _____ **NH MEDICAID PROVIDER #:** _____

ADDRESS: _____ **CITY/STATE/ZIP:** _____

TELEPHONE #: _____ **FAX #:** _____

MEDICAL NECESSITY CRITERIA FOR GASTRIC BYPASS SURGERY

ROUX – EN – Y GASTRIC BYPASS **LAPAROSCOPIC GASTRIC BANDING**

Roux-en-Y Gastric Bypass surgery **may** be covered for non-cosmetic indications for Medicaid recipients 18 years of age or older, but less than 65, when **all of the following criteria are met:**

The recipient has lost and maintained the loss of at 15% of body weight prior to scheduling surgery;
Percentage of body weight lost: _____%

AND

Body Mass Index (BMI) must be between 35 and 40 with life threatening co-morbidities of cardio-pulmonary problems, cardiovascular disease, uncontrolled severe Diabetes Mellitus, or medically refractory hypertension. Inadequate treatment of a co-morbid condition should not be used as an indication for Roux-en-Y Gastric Bypass surgery.

BMI: _____ **Co-morbidities:** _____

OR

BMI > for greater than 5 years
BMI: _____ **No. of Years:** _____

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

Please submit supporting documentation for verification of above information

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.



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AND

(All of the following must be checked to meet criteria)

- The recipient has participated in a physician-supervised/directed program including nutritional counseling, a low calorie diet, increased physical activity, and behavioral modification. This needs to be documented in the recipient's medical record. The nutrition and exercise program must be supervised and monitored by a physician. It must also be for a minimum cumulative total of 6 months or longer in duration and occur within 2 years of surgery, with participation in one program of at least 3 consecutive months. Diet plans of Jenny Craig, Weight Watchers etc. are not considered physician directed/monitored nutritional weight loss programs. Physician visits consisting of only pharmacological management are also not considered toward this goal.
- The recipient has the ability to adhere to lifestyle changes/modifications.
- The recipient does not have a specific correctable cause for the obesity, such as an endocrine metabolic disorder.
- A comprehensive psychological evaluation has been done to rule out an undiagnosed underlying psychological disorder, to determine the recipient is able to understand, tolerate and comply with all phases of care and is committed to long-term follow-up requirements
- The recipient has had previous conservative weight reduction attempts without long-term weight reduction.
- The recipient has attended AT LEAST three gastric bypass seminars at his/her own expense, and passed the tests given.

CERTIFICATION OF MEDICAL NECESSITY

I certify that the above information is true and accurate to the best of my knowledge.

Signature

Date

Please print:

Name/Title

Specialty

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8 Commerce Drive ■ 2nd Floor ■ Bedford, NH 03110 ■ FAX: (866) 499-9334 ■ PHONE: (866) 499-9335