



PROVIDER POLICIES & PROCEDURES

RESTORATIVE OBESITY SURGERY, ENDOLUMINAL (ROSE) PROCEDURE

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for the restorative obesity surgery, endoluminal (ROSE) procedure. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Individuals who have undergone gastric bypass surgery may experience weight regain over time. The ROSE procedure has been suggested as an option for the treatment of weight regain due to expansion of the gastric pouch or stoma. The stomach is accessed orally via an endoscope and reduced in size using an endoscopic closure device that creates multiple folds around the existing stoma to reduce diameter.

CLINICAL GUIDELINE

Coverage guidelines for the ROSE procedure are made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

The ROSE procedure is considered **investigational and therefore not medically necessary** as there is insufficient evidence in peer-reviewed, published, medical literature demonstrating the long term efficacy of the procedure in the management of weight gain following primary bariatric surgery.

NOTE: EPSDT Special Provision

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

Prior authorization for the ROSE procedure is required. Requests for coverage are reviewed in accordance with procedures in place for reviewing requests for surgical procedures. Coverage determinations are based upon a review of requested and/or submitted case-specific information.

Please note that authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. Payment is based on the individual having active coverage, benefits and policies in effect at the time of service.

To determine if a service or procedure requires prior authorization, CMAP Providers may refer to the *Benefit and Authorization Grids* summaries on www.ct.gov/husky by clicking on "For Providers" followed by "Benefit Grids". For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.

The following information is needed to review requests for the ROSE procedure:

1. Fully completed authorization request via on-line web portal; and
2. Documentation from the requesting physician supporting medical necessity.

EFFECTIVE DATE

This policy for the prior authorization for the ROSE procedure for individuals covered under the HUSKY Health Program is effective May 1, 2022.

LIMITATIONS

Not Applicable

CODE:

Code	Description
None	N/A

DEFINITIONS

1. **HUSKY A:** Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B:** Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children’s Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C:** Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D:** Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program:** The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP:** Connecticut’s implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **HUSKY Plus Physical Program (or HUSKY Plus Program):** A supplemental physical health program pursuant to Conn. Gen. Stat. § 17b-294, for medically eligible members of HUSKY B in Income Bands 1 and 2, whose intensive physical health needs cannot be accommodated within the HUSKY Plan, Part B.
8. **Medically Necessary or Medical Necessity:** (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual’s medical condition, including mental illness, or its effects, in order to attain or maintain the individual’s achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-

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specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

9. **Prior Authorization:** A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

REFERENCES

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- Goh YM, James NE, Goh EL, Khanna A. The use of endoluminal techniques in the revision of primary bariatric surgery procedures: a systematic review [published correction appears in *Surg Endosc.* 2020 Mar 13;:]. *Surg Endosc.* 2020;34(6):2410-2428. doi:10.1007/s00464-020-07468-w
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PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	March 2022	Approved at the March 9, 2022 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 21, 2022. Approved by DSS on March 24, 2022.

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