

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR**

ACTION REFERRAL

TO <i>Giese</i>	DATE <i>3-15-13</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000289	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Mr. Keck, COS, Deps, CMS file</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input checked="" type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
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4.			

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MAR 14 2013

Department of Health & Human Services
OFFICE OF THE DIRECTOR



UNIVERSITY MEDICAL GROUP

Department of Surgery
Eugene Langan, MD, Chairman

**Minimal Access &
Bariatric Surgery**

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Dear Director Keck and Associates,

My name is John Scott. I am a bariatric surgeon in Greenville, SC and have the honor as serving as the co-president for the Bariatric Society of the Carolinas, a diverse organization composed of bariatric surgeons and affiliated health care providers across the state of South Carolina. I am inquiring on the Medicaid status on the performance of the laparoscopic vertical sleeve gastrectomy as a primary bariatric operation.

As you may know, CMS recently reopened their bariatric coverage decision regarding the performance of sleeve gastrectomies as a primary bariatric operation. In South Carolina, Palmetto GBA has recognized this change in policy and, as of March 11th, this change will become active policy.

The Palmetto GBA policy change can be found in the medical policy update section of their website.

The laparoscopic vertical sleeve gastrectomy has been found to be an extremely effective tool in the battle against morbid obesity and has been an acceptable primary bariatric surgical procedure in many commercial plans within the state. The decision by CMS to reverse its policy and initiate sleeve coverage is a testament to the growing body of evidence that has supported its usage. It is a lower risk, high reward operation that can benefit the people who currently depend on SC Medicaid for health care.

I have also enclosed a letter that was addressed to CMS and the regional MAC providers that will include an update on the recent scientific literature surrounding the performance of the laparoscopic vertical sleeve gastrectomy.



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It will be a tremendous medical benefit for the citizens of South Carolina, as well as a direct financial benefit for the SC Medicaid program, if the sleeve gastrectomy becomes part of the acceptable bariatric coverage in the state.

Thank you for your consideration. I am available at any time to discuss this matter at 864-293-4636 or via email.

A handwritten signature in black ink, appearing to read "John Scott".

John Scott, MD FACS FASMBS
Greenville Hospital System University Medical Center
Co-President of the Bariatric Society of the Carolinas

November 12, 2012

The **American Society for Metabolic and Bariatric Surgery** appreciates the Centers for Medicare and Medicaid Services (CMS) recent decisions on:

- **Removal of the Non-Coverage Designation for the Laparoscopic Sleeve Gastrectomy (LSG)** on October 1, 2012 (Federal Register, page 53314:<http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf>)
- **Prior institution of coverage for the LSG** via local Medicare Administrative Contractors (MAC) (June 27, 2012, CAG-00250R2).
- **We are submitting our comments herein to assist you in crafting your Local Care Determination.**

We are gratified that the strong evidence base for LSG and the response from patients, surgeons, integrated health members and medical societies (**American College of Surgeons, American Society of Bariatric Physicians, Michigan Bariatric Surgery Collaborative, Society for Advanced Gastrointestinal Endoscopic Surgery (SAGES), and The Obesity Society**) helped to provide CMS with a compelling argument for LSG coverage.

As medical director for your local MAC, you have the ability to craft the *Local Care Determination (LCD)* for Laparoscopic Sleeve Gastrectomy on behalf of your Medicare Beneficiaries *without* any barrier given the removal of the Non-Coverage designation of the LSG in keeping with section 1862(a)(1)(A). We respectfully request that **your LCD be consistent with established clinical evidence and performance, current national CMS bariatric surgery guidelines, and other Medicare regional contractors and national insurers' standards and practices regarding LSG.** We anticipate that Medicare beneficiaries should receive the same level of obesity treatment coverage for LSG as over 100 million other Americans enjoy.

We are asking that you render a local care determination for laparoscopic sleeve gastrectomy with the following guidelines:

A. *Laparoscopic Sleeve Gastrectomy must be performed at CMS accredited centers*

- B. *The beneficiary has a body-mass index (BMI) ≥ 35 kg/m² with least one co-morbidity related to obesity or a (BMI) ≥ 40 alone. This is in keeping with the National Institutes of Health 1991 Consensus Conference Criteria for Bariatric Surgery as well as current national CMS and major insurer (Aetna, Cigna, United, Wellpoint) standards for bariatric surgery.*
- C. *Laparoscopic Sleeve Gastrectomy is a primary, stand-alone weight loss surgery.*
- D. *The beneficiary has been previously unsuccessful with medical treatment for obesity as determined by the treating physician. An arbitrary time period for medical weight loss may not be assigned and is a barrier to effective treatment. No evidence exists supporting a specific time frame for preoperative weight loss.*
- E. *All CMS beneficiaries should have the benefit of coverage for LSG regardless of age. Clinical evidence exists for LSG coverage in patients older than 61 years of age. The other CMS approved procedures of gastric banding and gastric bypass do not have an age restriction and LSG is exactly between the two procedures on the basis of safety and efficacy. Coverage of the LSG should not have age discrimination.*

The following is a detailed discussion on each point provided above:

I. Established coverage for the laparoscopic sleeve gastrectomy as a stand-alone procedure in CMS accredited centers for beneficiaries whose >35 with comorbidity or BMI>40 is safe, effective and comparable to CMS covered Gastric Bypass and Gastric Banding.

In keeping with the CMS Manual (Pub 100-03 Medicare National Determination, Transmittal 148, Change request 8028, Date 11/9/12), effective for claims with dates of service on or after June 27, 2012, Medicare Administrative Contractors acting within their respective jurisdictions may determine coverage of stand-alone laparoscopic sleeve gastrectomy (LSG) for the treatment of co-morbid conditions related to obesity in Medicare beneficiaries only when all of the following conditions a-c are satisfied.

- a. The beneficiary has a body-mass index (BMI) ≥ 35 kg/m²,
- b. The beneficiary has at least one co-morbidity related to obesity, and,
- c. The beneficiary has been previously unsuccessful with medical treatment for obesity.

Since the implementation of the original 2006 National Care Determination for Bariatric Surgery, we have witnessed an American surgical success story regarding patient safety in the bariatric surgery population. Encinosa detailed in a 2009 *Medical Care* article the steep decline in in-patient, 30-day and 180-day complications respectively, 37%, 24%, and 21%. In specific to the Medicare population, Nguyen in a

2010 *Archives of Surgery* noted a 33% reduction in mortality in Medicare beneficiaries following the NCD resulting in an overall bariatric surgery mortality rate 0.2%.

There are large, multi-center prospective studies to specifically compare the perioperative outcomes of the three main bariatric surgeries. In a 2010 *JAMA* article by Birkmeyer, a Michigan state-wide collaborative for bariatric surgery demonstrated a 30 day mortality rate of 0.14% for gastric bypass, 0.04% for gastric banding and ZERO % for sleeve gastrectomy. By utilizing the NSQIP database, Hutter in a 2011 article in *Annals of Surgery* found that the vertical sleeve gastrectomy was positioned between band and bypass for both complications and weight loss.

Furthermore, data from the ASMBS Bariatric Outcomes Longitudinal Database (BOLD) was presented at 2012 ASMBS Annual Meeting. BOLD is the world’s largest repository of bariatric surgery outcomes and was established partly in response to the original Bariatric Surgery NCD. From 2007-2010, over 268,898 bariatric surgeries were entered and reviewed in BOLD. The safety profile of the sleeve gastrectomy is between the two CMS-sanctioned bariatric procedures of gastric bypass and band.

SAFETY: GASTRIC BAND>SLEEVE GASTRECTOMY>GASTRIC BYPASS

30-Day Outcomes, BOLD 2007-2010

	Gastric Bypass (Roux-en-Y) N=136036	Adjustable Gastric Banding N=116898	Sleeve Gastrectomy N=15964
Deaths	186 (0.14%)	32 (0.03%)	13 (0.08%)
Serious Complications	1699 (1.25%)	298 (0.25%)	154 (0.96%)

In addition, the following studies provide clear and compelling evidence that the laparoscopic vertical sleeve gastrectomy is safe and effective in a randomized trial basis with both medical therapy and covered bariatric surgeries as controls.

Specifically, the studies include:

- A. In the March 26, 2012 issue of the *New England Journal of Medicine*, Schauer et al published “*Bariatric Surgery versus Intensive Medical Therapy in Obese Patients with Diabetes.*” In this randomized controlled trial, the efficacy of intensive medical therapy alone versus Roux-en-Y gastric bypass or sleeve gastrectomy in 150 obese patients with uncontrolled type 2 diabetes was performed. Both bariatric surgeries out-performed intensive medical therapy in a convincing fashion. Also, of note, the sleeve gastrectomy outcomes were equivalent to Roux-en-Y gastric bypass, a CMS covered surgical benefit. At the end of the one-year trial, hemoglobin A1C was 7.5 for intensive medical therapy, 6.4 for Roux-en-Y gastric bypass, and 6.6 for sleeve gastrectomy. As expected,

- weight loss outcomes had similar results namely, 34.4 for intensive medical therapy, 26.8 for Roux-en-Y gastric bypass, 27.2 for sleeve gastrectomy. Of note, when examining serious adverse events requiring hospitalizations, intensive medical therapy and sleeve gastrectomy were equivalent! (9 vs. 8%, respectively). This trial was published in the *New England Journal of Medicine*, which leads all general medical journals in its impact factor.
- B. In the April 16, 2012 issue of the *Archives of Surgery*, Leonetti and colleagues published *Obesity, Type 2 Diabetes Mellitus, and Other Comorbidities: A Prospective Cohort Study of Laparoscopic Sleeve Gastrectomy vs. Medical Treatment*. From trial initiation to trial end at 18 months, the medical treatment control group gained weight and saw modest declines in Fasting Plasma Glucose (BMI, 39 to 39.8; FPG, 183 to 150). In contradistinction, the Laparoscopic Sleeve Gastrectomy treatment group saw substantial declines in both weight and Fasting Plasma Glucose (BMI, 41.3 to 28.3; FPG, 166 to 97). Cardiac risk factor assessment showed consistent superiority of Laparoscopic Sleeve Gastrectomy over medical therapy particularly for Triglycerides (LSG, 169 to 97; Medical, 199 to 173).
- C. In the April 2012 issue of *Surgical Endoscopy*, Helmio et al published *SLEEVEPASS: A randomized prospective multicenter study comparing laparoscopic sleeve gastrectomy and gastric bypass in the treatment of morbid obesity: preliminary results*. In this study of 240 patients, early safety outcomes for the sleeve gastrectomy were superior to Roux-en-Y gastric bypass with no mortalities in either group.
- D. Himpens in *Annals of Surgery* 2010 presented this six- year study demonstrating durability of the three year results originally presented in *Obesity Surgery* 2006 with a 53.3 % Excess Weight Loss at six years. Three-year results were also presented by Karamanakos in *Obesity Surgery* 2012 with a 68% Excess Weight Loss. Long-term results are also present in *Obesity Surgery* 2012 where Prasad et al published *An Analysis of 1–3-Year Follow-up Results of Laparoscopic Sleeve Gastrectomy* demonstrating longevity of results with 66% Excess Weight Loss at three years.

II. Preoperative Weight Loss Requirement

There has been recent consideration that a Local Care Determination for LSG includes a mandated documented preoperative weight loss before approving bariatric surgery. This non-evidence-based approach is a clear barrier to access to care for patients in need. There are NO studies documenting the efficacy of this approach. There are several studies which show that a) there is no benefit in terms of long-term weight loss and compliance, b) it leads to patients dropping out of the bariatric approach, c) there is evidence that this leads to further aggravation of obesity co-morbidities when compared to patients who undergo bariatric surgery, and d), most disturbing of all, there is an increased mortality in patients who have been evaluated for bariatric surgery but do not undergo it for insurance denial or other reasons. These patients have had numerous attempts at dietary weight loss, through multiple programs, over many years.

Of note, effective August 1, 2012, BCBS of Florida has eliminated their required timeline (**previously 6 months**) for medically managed weight loss AND documented history of obesity requirement (**previously 5 years**). BCBS of Florida covers approximately 2.6 million medical lives. Health Care Services Corporation (HCSC), the parent company of BlueCross BlueShield (BCBS) of Illinois, Texas, Oklahoma, and New Mexico has eliminated the mandatory six-month weight loss requirement prior to bariatric surgery.

It is the position of the American Society for Metabolic and Bariatric Surgery that the requirement for documentation of prolonged preoperative diet efforts before insurance approval of bariatric surgery services is inappropriate, given the absence of medical evidence to support this practice. These policies are discriminatory without supporting evidence and may delay, impede, or otherwise interfere with life-saving and cost-effective treatment. Please find below a brief summary of some relevant publications on preoperative weight loss and its impact upon patients. A link to our recent position statement on preoperative weight loss with further evidence review follows at the conclusion of this letter.

Brief Literature Review of Preoperative Weight Loss for Bariatric Surgery Patients

- Janz E. Number of weight loss attempts and maximum weight loss before Roux-en-Y laparoscopic gastric bypass surgery are not predictive of postoperative weight loss. *Surg Obes Relat Dis* 2009;5:208-11.
- Jamal MK. Insurance-mandated preoperative counseling does not improve outcome and increases dropout rate in patients considering gastric bypass for morbid obesity. *Surg Obes Relat Dis* 2006;2:122-7.
- Harakeh AB. The natural history and metabolic consequences of morbid obesity for patients denied coverage for bariatric surgery. *Surg Obes Relat Dis* 2010.
- MacDonald KG, Jr. The gastric bypass operation reduces the progression and mortality of non-insulin-dependent diabetes mellitus. *J Gastrointest Surg* 1997;1:213-20.
- Flum DR. Impact of gastric bypass operation on survival: A population-based analysis. *J Am Coll Surg* 2004;199:543-51.

- Sowenimo. Natural history of morbid obesity without surgical intervention. *Surg Obes Relat Dis* 2007;3:73-7.

III. Laparoscopic Vertical Sleeve Gastrectomy Coverage for all CMS Beneficiaries Regardless of Age.

There are numerous data, which demonstrate that laparoscopic sleeve gastrectomy is safe and effective in older patients.

- A. Ramirez and colleagues published *Outcomes of Bariatric Surgery in Patients over 70 years of Age* in *SOARD* 2012. This study demonstrated 55% reduction in all medications with no mortalities for all three represented surgeries of banding, bypass and sleeve gastrectomy.
- B. Specific to laparoscopic sleeve gastrectomy, Leivonen and colleagues demonstrated in *Laparoscopic Sleeve Gastrectomy in Patients over 59 Years: Early Recovery and 12-Month Follow-Up* for *Obesity Surgery* 2011 that patients older than 60 years of age compared to patients younger than 60 years of age had similar weight loss and no mortality in either group.
- C. O'Keefe et al in *Bariatric Surgery Outcomes in Patients Aged 65 Years and Older at an American Society for Metabolic and Bariatric Surgery Center of Excellence* published in *Obesity Surgery* 2010 found that all three weight loss surgeries (band, bypass, sleeve) were effective in patients ≥ 65 years of age, producing significant EWL, reduction in daily medication use, and improvement in QOL. All surgeries also associated with a Zero 30 day-mortality rate and a low morbidity profile.
- D. A Poster of Distinction at the 2012 ASMBS Annual Meeting specifically compared outcomes for patients age >65 vs. <65 for the three procedures of gastric banding, sleeve gastrectomy and gastric bypass. 14,476 patients who underwent bariatric surgery between Jun 2007 and Dec 2010 were aged > 65 were identified. The 30-day mortality rate for older LSG patients was lower than that of gastric bypass patients (0.39% vs. 0.5%) as was the rate of serious complications (1.54% vs. 2.84%).
- E. Given the recent discussion of extending LSG only to CMS beneficiaries with age <61 , ASMBS recently accessed the BOLD database to specifically exam the comparative bariatric surgery outcomes for the populations $>$ and < 61 years of age. As in every other comparative safety study, sleeve gastrectomy was positioned between gastric banding and gastric bypass.

30-Day Outcomes of Patients > 61 years, BOLD 2007- Sept 2011

	Gastric Bypass (Roux-en-Y) (n=13957)	Gastric Banding (n=12129)	Sleeve Gastrectomy (n=1905)
%, 30 Day Mortality	0.65	0.15	0.31
%, 30 Day Serious Adverse Events	5.28	0.86	2.94
%, 30 Day Readmissions	9.36	3.09	6.30
%, 30 Day Reoperations	5.77	1.53	4.04

Despite that lack of coverage, the above citations lend support to LSG coverage for all CMS beneficiaries regardless of age. A specific comment from initial LCD drafts indicates that that LSG is not commonly considered for older patients. This is an obvious statement of fact that was due to CMS lack of coverage for those older patients in need. In addition, another LCD draft comment noted that no RCTs were present that compared LSG to medical management or another bariatric surgical approach that focused solely on adults who were ≥ 65 years old or allowed to discriminate subpopulation findings. All data point to LSG being positioned exactly between gastric band and gastric bypass in general populations and older populations are examined the same order of safety is maintained between the three procedures.

With five randomized trials and almost 300,000 bariatric surgery registry patients supporting the conclusion that sleeve gastrectomy is comparable to other bariatric surgery procedures for safety and efficacy, there is no compelling need for a RCT. An RCT is not optimal or even appropriate for determination of the incidence of infrequent complications over a period of years. A RCT for laparoscopic sleeve gastrectomy for age >61 beneficiaries is unnecessarily costly and an inefficient use of resources for such a small patient population (<5000 pts.).

Also noted in some draft LCDs are the citations for the Flum and Demaria studies specifically: “As Flum noted, age is an important factor in adverse outcomes from bariatric surgery. DeMaria noted that the “role of bariatric procedures in patients outside the commonly defined age range (18 to 60 years) is not well established” and reported advanced patient age as a major contributor to mortality.” Both of these studies are essentially historic performed before the advent of modern, laparoscopic, accredited bariatric surgery. **The Flum and Demaria studies are not representative of current bariatric surgery practice.** As we have stated previously, the implementation of the accreditation system for bariatric surgery has resulted in striking advances in patient safety.

To demonstrate the enormous benefit achieved over time in bariatric surgery, Dr.

Ninh Nguyen from University of California-Irvine partnered with the University Health Consortium to derive the following data regarding bariatric surgery in academic centers. This analysis compares two patient populations (age, 18-60 vs. >60) during the time periods prior to accreditation (1999-2005) and following accreditation (2008-2012). As demonstrated in the tables below, **contemporary (2008-2012) in-patient bariatric surgery mortality for elderly patients is better than the mortality seen in younger patients in the earlier time period (1999-2005), respectively, 0.11 vs. 0.3%.** This clearly demonstrates the Flum and DeMaria papers to be historical antecedents of current, modern, laparoscopic bariatric surgery.

Outcomes of Bariatric Surgery in the Non-elderly compared to Elderly Patients, 1999-2005. Elderly is 2.7% of study population.

Variables	Non-elderly (19-60 years)	Elderly (>60 years)
Total no. of cases	47,936	1,339
Mean length of stay (days)	3.8 ± 3.5	4.9 ± 4.0†
In-hospital mortality (%)	0.3	0.7*
Observed-to-expected mortality ratio	0.7	0.9

* p<0.05, Chi-Square tests

Outcomes of Bariatric Surgery in the Non-elderly compared to Elderly

Patients, 2008-2012. Elderly is 10.1% of study population.

Variables	Non-elderly (18-60 years)	Elderly (>60 years)
Total no. of cases	49,339	5,561
Mean length of stay (days)	2.2 ± 2.2	2.5 ± 3.6
Patients requiring ICU stay (%)	5.4	7.8
30-day readmission (%)	1.8	1.9

In-hospital mortality (%)	0.02	0.11
Observed-to-expected mortality ratio	0.24	0.78

In addition, it appears the laparoscopic sleeve gastrectomy has lower incidence of both peptic ulcers and nutritional deficiencies (Kehagis, *Obesity Surgery*, 2011 and Gehrer, *Obesity Surgery*, 2010). All of these particular advantages of the Laparoscopic Sleeve Gastrectomy hold import for select groups of Medicare patients who require normal absorption of needed medications (Transplant patients), endoscopic surveillance (prior Gastrointestinal Reconstructive Surgical patients), and routine use of NSAIDS (Arthritis patients).

Laparoscopic Sleeve Gastrectomy:
Appropriate Coverage and Reimbursement

Your local coverage decision will be in keeping with other payors and organizations and allows us to offer the same treatment to Medicare patients that other patients already enjoy.

For example, effective January 2010, the American Medical Association assigned a Current Procedural Terminology code to describe LSG as a primary single-stage restrictive weight loss procedure. Recently, on October 1, 2011, CMS decided to assign Laparoscopic Sleeve Gastrectomy to ICD 43.82 and Open Sleeve Gastrectomy to ICD 43.89. We appreciate CMS's decision that provides for both of these ICD-9 codes to be grouped to DRG 619, 620 and 621, OR procedures for obesity.

Along with the removal of the non-coverage designation for LSG, CMS removed the standardized procedural valuation for CPT 43775 (Sleeve Gastrectomy) from the CMS website with the publication of the NCD deferring coverage to its Local Contractors. This may lead to variation in payment and beneficiary access for this procedure when covered. The ASMBS endorses the AMA/Specialty Society RVS Update Committee (RUC) valuation last published in 2012. This peer-reviewed and standardized process represents the standard for procedural valuation. As of 2012, this committee valued CPT 43775 as follows:

Work RVU	21.56
Facility Practice Expense RVU	11.59
PLI RVU	4.60
Total Facility RVU	37.75
Medicare Facility Payment	\$1284.92

In keeping with the CMS Manual (Pub 100-03 Medicare National Determination,

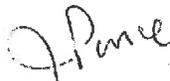
Transmittal 148, Change request 8028, Date 11/9/12), we note that the effective date of LSG coverage was June 27, 2012 and the implementation date is December 10, 2012. **This signifies that all CMS cases performed after June 27, 2012 should be reimbursed even retroactively.** We also ask that you specifically list your coverage decision publically so patients and insurers alike can be assured of coverage given that Medicare surgical services are not provided with pre-authorization.

Beyond regulatory recognition, an overwhelming number of payors have chosen to provide vertical sleeve gastrectomy coverage to their beneficiaries. **In sum, current national coverage for vertical sleeve gastrectomy extends to over 104 million patients.** The long list of payors providing vertical sleeve gastrectomy coverage includes, but is not limited to the following: Aetna; Amerihealth; BC/BS Arkansas; BC/BS Nebraska; BS California; CareFirst BC/BS; Cigna; Emblem Health; Excellus BC/BS; HCSC (parent company for BC/BS Texas, Oklahoma, New Mexico, and Illinois); HealthNet; HMSA (BC/BS HI); Horizon BC/BS New Jersey; Federal BC/BS; Independence BC; BC/BS Texas; Medica; Michigan-BC/BS; Neighborhood Health Plan; Priority Health; QualCare; United Healthcare.

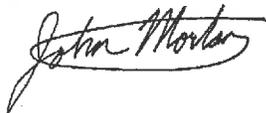
Conclusion

We believe the health outcomes evidence for the laparoscopic sleeve gastrectomy is overwhelmingly favorable and clearly meets the indications for a Local Coverage Determination. The laparoscopic sleeve gastrectomy is safe, effective and comparable to the current CMS approved bariatric surgery procedures. The indications for the procedure should be consistent with CMS indications for bariatric surgery, national insurers, and 1991 NIH Consensus Conference Criteria for Bariatric Surgery. We ask that your LCD for the laparoscopic sleeve gastrectomy be free of any age or preoperative weight loss restrictions, ensuring there is equitable, consistent, and rational access for all CMS beneficiaries. We urge its inclusion as a covered benefit so Medicare patients may equally benefit with other insured obese patients. We welcome any and all opportunities to discuss this further with you as we all continue in our shared mission of providing optimal, safe, and effective care for our obese patients.

Sincerely,



Jaime Ponce, MD, FASMBS
President, ASMBS



John Morton, MD, MPH, FASMBS
Secretary Treasurer & Access to Care
Committee Chair, ASMBS



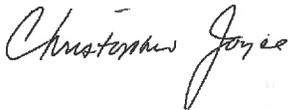
Robin Blackstone, MD, FASMBS
Past President, ASMBS



Wayne English, MD
Access to Care Committee Co-Chair,
ASMBS



Daniel Jones, MD



Christopher Joyce, MD



Keith Kim, MD

Teresa LaMasters, MD



Bradley Needleman, MD



Joe Northrup, MD



Mitch Roslin, MD



Michael Schweitzer, MD



John Scott, MD



Lloyd Stegemann, MD



Brandon Williams, MD

Addendum

ASMBS Letter to CMS <http://bit.ly/LCwefP>

PPT/LSG Bibliography <http://bit.ly/OcUkv2>

National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Morbid Obesity <http://go.cms.gov/Lxv9kL>

CMS and Sleeve Gastrectomy: Call to Action for all Members
<http://bit.ly/NNKsLw>

ASMBS Response to CMS Sleeve Coverage Decision
<http://bit.ly/OernPj>

Access to Care Alert- The CMS Final Decision

<http://bit.ly/NDjd5l>

Sleeve Gastrectomy ICD-9 Coding and DRG Mapping-New Ruling

Published <http://bit.ly/pCArWe>

Preoperative Weight Loss

<http://bit.ly/MXbhbm>

Updated Position Statement on Sleeve Gastrectomy as a Bariatric

Procedure <http://bit.ly/LxyCjd>