

Medical Policy: Bariatric Surgery (Commercial)



POLICY NUMBER	LAST REVIEW DATE	APPROVED BY
MG.MM.SU.18pC2v2	06/10/2022	MPC (Medical Policy Committee)

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Definitions

Bariatric surgical procedure types	<p>Restrictive, malabsorptive and combined, all of which may be performed using either the laparoscopic or open approach.</p> <ol style="list-style-type: none"> 1. Restrictive — the basic philosophy of restrictive procedures is to create a small gastric reservoir that forces the patient to eat less at any one time. This objective is achieved by reducing the size of the stomach pouch to 30 mL or less and leaving only a small channel to the remaining stomach. 2. Malabsorptive — the goal of purely malabsorptive procedures is to bypass a major portion of the absorptive surface of the small intestine for the achievement of rapid, sustained weight loss without a necessary change in eating habits. Purely malabsorptive procedures (without a restrictive component) are not recommended because of the potential for complications, including liver failure and electrolyte depletion. 3. Combined restrictive and malabsorptive (hybrid techniques) — the basic philosophy of combined restrictive and malabsorptive procedures is to balance the benefits and risks of the two approaches.
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Body Mass Index (BMI)	A quantitative method of defining obesity in a ratio of weight to height (kg/m ²).	
Classification	Class	BMI
	Overweight	25–29.9 kg/m ²
	Obese (class I)	30–34.9 kg/m ²
	Severe obesity (class II)	35–39.9 kg/m ²
	Clinically severe (also referred to as extreme or morbid) obesity (class III)	40–49.9 kg/m ²
	Super obesity	50–59.9 kg/m ²
	Super-super obesity	60+ kg/m ²
Biliopancreatic Diversion with duodenal switch (BPD/DS)	A combined malabsorptive / restrictive procedure whereby a suprapapillary Roux-en-Y duodeno-jejunostomy is performed in combination with a 70%–80% greater curvature gastrectomy (sleeve resection of the stomach; continuity of the gastric lesser curve is maintained while simultaneously reducing stomach volume). A long-limb Roux-en-Y is then created. The efferent limb acts to decrease overall caloric absorption and the long biliopancreatic limb, diverting bile from the alimentary contents, is intended specifically to induce fat malabsorption.	
Laparoscopic adjustable gastric banding (LAGB)	A gastric-restrictive implant device used as an alternative to a gastric-restrictive surgery procedure to treat morbid obesity. The system consists of a band of silicone elastomer with an inflatable inner shell and a buckle closure connected by tubing to an access port placed outside the abdominal cavity. The inner diameter of the band can be readily adjusted by the addition or removal of saline through the access port. The band is placed laparoscopically around the upper stomach, 1 cm below the esophagogastric junction. (Must be FDA-approved for Plan consideration)	
Roux-en-Y gastric bypass (RYGB)	A large portion (approximately 90%) of the stomach is excluded. A gastric pouch is created and anastomosed to the proximal jejunum, causing weight reduction due to a reduction of food intake and mild malabsorption.	
Sleeve gastrectomy	A new procedure that is becoming increasingly popular. In this operation, a tubular stomach is created along the lesser curvature by excising the greater curvature. Approximately an 80–90% gastrectomy is performed. This is a restrictive procedure and absorption remains normal.	

<p>Vertical gastric banding (VGB) / vertical-banded gastroplasty (VGB) (vertical gastric stapling or partitioning)</p>	<p>A vertical row of staples and a horizontally placed reinforcing band are positioned across the stomach, creating a proximal pouch and narrowed food outlet. Patients become full post ingestion of only small food amounts.</p>																								
<p>The Obesity Surgery Mortality Risk Score (OS-MRS)</p>	<p>A risk stratification tool that physicians should utilize when determining candidacy of the BMI ≥ 50 kg/m² member. The OS-MRS assigns 1 point to each of 5 preoperative variables: Age, hypertension, male gender, known risk factors for pulmonary embolism (i.e., previous thromboembolism, preoperative vena cava filter, hypoventilation, pulmonary hypertension) and BMI.</p> <table border="1" data-bbox="597 766 1455 1432"> <thead> <tr> <th colspan="2">Obesity Surgery Mortality Risk Score</th> </tr> <tr> <th>Risk factor</th> <th>Points</th> </tr> </thead> <tbody> <tr> <td>Age > 45 years</td> <td>1</td> </tr> <tr> <td>Hypertension</td> <td>1</td> </tr> <tr> <td>Male sex</td> <td>1</td> </tr> <tr> <td>Risk factors for pulmonary embolism</td> <td>1</td> </tr> <tr> <td>Body mass index ≥ 50 kg per m²</td> <td>1</td> </tr> <tr> <td></td> <td>Total:</td> </tr> <tr> <td><i>Risk group (score)</i></td> <td><i>Postoperative mortality risk (deaths/total number of patients who underwent bariatric surgery)</i></td> </tr> <tr> <td>Low (0 or 1 points)</td> <td>5/2164 (0.2%)</td> </tr> <tr> <td>Moderate (2 or 3 points)</td> <td>25/2142 (1.2%)</td> </tr> <tr> <td>High (4 or 5 points)</td> <td>3/125 (2.4%)</td> </tr> </tbody> </table>	Obesity Surgery Mortality Risk Score		Risk factor	Points	Age > 45 years	1	Hypertension	1	Male sex	1	Risk factors for pulmonary embolism	1	Body mass index ≥ 50 kg per m ²	1		Total:	<i>Risk group (score)</i>	<i>Postoperative mortality risk (deaths/total number of patients who underwent bariatric surgery)</i>	Low (0 or 1 points)	5/2164 (0.2%)	Moderate (2 or 3 points)	25/2142 (1.2%)	High (4 or 5 points)	3/125 (2.4%)
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Guideline

Members may be eligible for coverage of the above-captioned surgical procedures (in conjunction with cholecystectomy if such is requested) when **all** of the following criteria are met:

1. Age ≥ 18 .¹
2. Full growth achieved.
3. Absence of specific obesity etiology (i.e., endocrine disorders, e.g., adrenal or thyroid conditions, or treatment of metabolic cause provided, as applicable [does not pertain to diabetes.]).
4. Psychological clearance by a mental health professional.

If the member has received any behavioral health issue intervention (i.e., counseling

or drug therapy) within the past 12 months, then the mental health provider should indicate that the issue of surgery has been discussed with the member and that there are no identified contraindications to the proposed surgery.

In addition, the member should have no history of substance abuse, or if there is a positive history, the documentation should indicate that the member has been substance abuse free for > 1 year or that he/she is in a controlled treatment program and is stabilized.

Other contraindications include active eating disorders, active substance abuse and untreated psychiatric illness such as suicidal ideation, borderline personality disorder, schizophrenia, terminal illness and uncontrolled depression.

AND

5. BMI \geq 40 kg/m² **or** BMI 35–39.9 kg/m² with \geq 1 significant comorbidity.

Accompanying documentation of the following associated comorbid conditions and associated problems must be submitted; any of the following are applicable:

- a. Daily functional interference to the extent that performance is extensively curtailed.²
- b. Documented circulatory insufficiency.
- c. Documented physical trauma secondary to obesity complications, which causes the member to be incapacitated.
- d. Documented respiratory insufficiency.
- e. Documented primary disease complication, as applicable:
 - i. Coronary heart disease and other atherosclerotic diseases.
 - ii. Hypertension.
 - iii. Osteoarthritis.
 - iv. Obstructive sleep apnea.
 - v. Type 2 diabetes.

Gastric Band Adjustments

Appropriate as follows:

1. Reduction of band volume: Complaints of difficulty swallowing, persistent reflux or heartburn, nighttime coughing or regurgitation.

Reduction of band volume may also be appropriate in the setting of maladaptive eating habits such as eating only soft, carbohydrate and fat laden food due to inability to tolerate any solid foods. These complaints, however, should be taken in context with member's compliance with dietary follow up and recommendations.

2. Increase in band volume: Increased hunger, increased portion sizes.

Adjustments would be expected at approximately 6-week intervals until appropriate fill volume has been achieved (member is experiencing early and prolonged satiety with small meal sizes, satisfactory weight loss).

Adjustments should be performed in the outpatient setting and without fluoroscopic guidance unless the port is not palpable, there is difficulty accessing the port, or leakage is suspected.

- ¹ Surgical requests for members < 18 years may be reviewed on a case-by-case basis and should only be performed in centers where there is a multidisciplinary approach to pediatric obesity and only in rare circumstances (e.g., Prader-Willi syndrome).
- ² The member must be unable to participate in employment and/or normal activities as a result of the clinically severe obese condition, which could be resolved by weight reduction (e.g., treatable joint disease).

Surgical Revision

Members are eligible for coverage of a surgical revision of a previous gastric restrictive surgery if it is medically necessary as a result of a complication of the original procedure, i.e.:

1. Staple disruption.
2. Obstruction or chronic stricture.
3. Severe esophagitis.
4. Dilatation of the gastric pouch in a member who experienced appropriate weight loss prior to the dilatation.

Note: Laparoscopic adjustable banding revisional surgery will be covered for band slippage or erosion, both of which are deemed urgent medical conditions.

Surgical Repetition

Members are eligible for coverage of repeat bariatric surgery if both of the following criteria are met:

1. Insufficient weight loss (success defined as a weight loss of > 50% of excess body weight)
2. The medically necessary criteria (as outlined above) are met.

Note: Member compliance with prescribed post-procedure nutrition and exercise program is prerequisite to consideration.

Postsurgical Panniculectomy Requests

(See [Cosmetic and Reconstructive Surgery Procedures](#) and/or [Abdominoplasty/Panniculectomy](#))

Limitations/Exclusions

1. Surgical revision is not considered medically necessary for members who have a functional operation (without any evidence of medical abnormality) because of inadequate weight loss.
2. Cholecystectomies performed incidental to bariatric surgery will only be covered if the bariatric surgery has been authorized/approved.
3. Repair of an asymptomatic or incidentally identified hiatal hernia (CPT codes 43280, 43281, 43282, 43289, 43499 or 43659) will be denied as incidental/inclusive procedures when reported with bariatric surgery code ranges 43770–43775 and 43842–43848, 43644, 43645, 43886, 43887 or 43888). Modifier 59 will not override these codes as hiatal hernia repair is considered an integral part of obesity surgery.
4. Case-by-case consideration for preoperative esophagogastroduodenoscopy (EGD) (CPT 43235) will be given for members symptomatic of gastroesophageal reflux disease (GERD) (e.g., heartburn, regurgitation, dysphagia, etc.).
5. Transoral outlet reduction (TORe) (e.g., the Overstitch device, CPT 43659) — a minimally invasive endoscopic revision procedure performed in patients with weight

regain or inadequate weight loss following Roux-en-Y gastric bypass — is considered investigational due to insufficient evidence of therapeutic value.

6. All other gastric bypass/restrictive procedures (and other treatment modalities not listed above as medically necessary) are considered investigational due to insufficient evidence of therapeutic value. These include, but are not limited to, minimally invasive endoluminal surgical restrictive surgical techniques (e.g., EndoGastric StomaphyX™ endoluminal fastener and delivery system); laparoscopic gastric plication/laparoscopic greater curvature plication (LGCP), with or without gastric banding; balloon-type systems (e.g., ReShape® Integrated Dual Balloon System) and vagus nerve-blocking devices (e.g., MAESTRO® Rechargeable System).

Applicable Procedure Codes

43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43659	Unlisted laparoscopy procedure, stomach
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy

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43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only
43999	Unlisted procedure, stomach
47562	Laparoscopy, surgical; cholecystectomy
47600	Cholecystectomy
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline

Applicable ICD-10 Diagnosis Codes

E66.01	Morbid (severe) obesity due to excess calories
Z68.35	Body mass index (BMI) 35.0-35.9, adult
Z68.36	Body mass index (BMI) 36.0-36.9, adult
Z68.37	Body mass index (BMI) 37.0-37.9, adult
Z68.38	Body mass index (BMI) 38.0-38.9, adult
Z68.39	Body mass index (BMI) 39.0-39.9, adult
Z68.41	Body mass index (BMI) 40.0-44.9, adult
Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.43	Body mass index (BMI) 50-59.9, adult
Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.45	Body mass index (BMI) 70 or greater, adult
Z98.84	Bariatric surgery status

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Specialty matched clinical peer review.

Revision history

DATE	REVISION
08/12/2022	Added Overstitch device as investigational
12/10/2021	Added case-by-case consideration language for preoperative esophagogastroduodenoscopy (EGD) for members symptomatic of gastroesophageal reflux disease (GERD)
02/12/2021	Removed prerequisite for 2 years of insufficient weight loss within Surgical Repetition criteria Added clarification of incidental cholecystectomies under Exclusions/Limitations #2
01/01/2020	Retired MCG criteria for this service ConnectiCare has adopted the clinical criteria of its parent corporation EmblemHealth