

Bariatric Surgery (Adults)

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Clinical guidelines are applicable according to policy and plan type. The Plan may delegate utilization management decisions of certain services to third parties who may develop and adopt their own clinical criteria.

Coverage of services is subject to the terms, conditions, and limitations of a member's policy, as well as applicable state and federal law. Clinical guidelines are also subject to in-force criteria such as the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) for Medicare Advantage plans. Please refer to the member's policy documents (e.g., Certificate/Evidence of Coverage, Schedule of Benefits, Plan Formulary) or contact the Plan to confirm coverage.

Summary

Morbid (clinically severe) obesity is a condition in which body fat accumulates to a level that can cause or inhibit the treatment of life-threatening medical comorbidities. Initial treatment steps include a regimented plan of diet and lifestyle changes, often designed and supervised by a team of healthcare professionals. Morbidly obese patients who have failed traditional treatment methods and are being treated for associated high-risk conditions including diabetes, hypertension, or obstructive sleep apnea, may be candidates for bariatric surgery. Bariatric surgery procedures attempt to reduce fat tissue accumulation through restrictive or malabsorptive approaches and can often be performed as open or laparoscopic surgery. Restrictive surgeries function by decreasing the effective size of the stomach, creating a sensation of early satiety and preventing the patient from intaking large meals. Malabsorptive procedures function by rearranging the flow of food through the digestive system to decrease overall digestion/absorption of calories. Some procedures combine restrictive and malabsorptive approaches. Additionally, a comprehensive post-operative plan of diet, exercise, and behavioral modification is critical in achieving durable weight loss outcomes, where success is defined as reduction in excess body weight by 50% and returning to within 30% of a patient's ideal body weight. Treatment plans and surgical options differ for adults and adolescents [see CG009: Bariatric Surgery (Adolescents)]. Bariatric surgery always requires prior authorization.

Definitions

“Body Mass Index (BMI)” relates body weight to height, defined as body mass divided by body height squared in units of kg/m² and is used to risk-stratify members.

“Class I Obesity” is defined as a BMI of 30 - 34.9.

“Class II Obesity” is defined as a BMI 35 - 39.9.

“Class III Obesity” is defined as a BMI ≥ 40 .

“Bariatric” is a term referring to the treatment of obesity.

“Open Surgery” refers to a procedure where a large incision allows for direct visualization and access to intra-abdominal organs.

“Laparoscopic Surgery” or minimally invasive surgery refers to a procedure often consisting of multiple small incisions allowing the use of a small camera (laparoscope) and several thin instruments.

“Bariatric Surgery” is surgery on the stomach and/or intestines to assist with weight loss in patients with severe or extreme obesity (Classes II and III). Bariatric surgery can be done via restrictive procedures, malabsorptive procedures, or a combination of the two.

- “Restrictive Procedures” decrease digestive capacity, promote early satiety, and decrease the speed at which food moves through the digestive system.
 - “Adjustable Gastric Banding (AGB)” is where an adjustable band is placed around the outside of the stomach and can be tightened or loosened to achieve the desired effect. It functions by decreasing the stomach capacity and limiting the speed at which food can enter the lower part of the stomach. This procedure is often performed laparoscopically. A unique feature of the procedure is that it is reversible through removal of the band. Risks include developing band slippage and/or erosion through the stomach wall in 2-5% of cases. Positioning is important and, if incorrect, can be ineffective and cause vomiting. The Lap-Band™ is an example AGB device.
 - “Sleeve Gastrectomy (SG)” is where the greater curvature of the stomach is resected, resulting in a tube or sleeve-like shape to restrict capacity. This can be performed via open incision or laparoscopically. It can also be combined with malabsorptive surgery in a sequential 2-stage procedure or at a later date if adequate weight loss is not obtained.
- “Malabsorptive Procedures” reduce digestion and absorption of calories through re-arrangement of the digestive system:
 - “Gastric Bypass (Roux-en-Y Gastric Bypass [RYGB])” combines restrictive and malabsorptive features. The stomach is divided into either a horizontal or vertical plane similar to banded gastropathy (restrictive). The Roux-en-Y procedure then takes the small intestine and creates a “Y” shape, where the two legs of the “Y” allow a portion of food

to pass through undigested while retaining a limited digestive capacity for the remaining food (malabsorptive). A gastric bypass can be performed via open incision or laparoscopically. Expected weight loss at two years is approximately 70%.

- “Biliopancreatic Diversion (BPD [Scopinaro Surgery])” was originally proposed to alleviate the metabolic concerns of original bypass procedures. It consists of a subtotal gastrectomy (similar to sleeve gastrectomy) and diversion of the biliopancreatic secretions. There is a high incidence of vitamin/nutrient deficiency and gallstones, and a prophylactic cholecystectomy is routinely performed at the time of procedure. Duodenal switch is also often performed, which preserves the pylorus, resulting in less metabolic complications. The BPD can be performed via open incision or laparoscopically.

“Repair” refers to a procedure or operation performed to correct and/or treat a complication of a prior surgery.

“Conversion” is when a prior procedure is converted to a new one—for example, when there are complications or inadequate weight loss with the primary surgery. An example is sleeve gastrectomy conversion to Roux-en-Y gastric bypass.

“Revision” refers to a procedure or operation performed due to failure of desired outcome of prior surgery or to reverse/adjust a prior surgery. It does not result in a new procedure, unlike conversion.

Clinical Indications

Procedures & Length of Stay

The Plan considers the following procedures and settings for the treatment of morbid obesity in adults (age ≥18) medically necessary when criteria are met:

- Roux-en-Y gastric bypass (<150cm)
 - Open - 2 days inpatient admission
 - Laparoscopic - Ambulatory, which may include an overnight stay
 - An inpatient admission for a higher level of care with a laparoscopic approach may be considered medically necessary when the member meets MCG Ambulatory Surgery Exception Criteria (CG-AEC)
- Adjustable gastric banding
 - Laparoscopic - Ambulatory, which may include an overnight stay
 - An inpatient admission for a higher level of care with a laparoscopic approach may be considered medically necessary when the member meets MCG Ambulatory Surgery Exception Criteria (CG-AEC)
- Sleeve gastrectomy
 - Open - 1 day inpatient admission
 - Laparoscopic - Ambulatory, which may include an overnight stay

3. Failure to achieve and maintain successful long-term weight loss via non-surgical therapy; *and*
4. The proposed bariatric surgery includes a comprehensive pre- and post-operative plan to evaluate nutritional status, overall health, and any specific surgical risks:
 - a. Preoperative evaluation to rule out and treat any other reversible causes of weight gain/obesity, may include routine lab testing, screenings, and risk evaluations such as:
 - i. Fasting blood glucose, fasting lipid panel, complete blood count (CBC), lipid/kidney function testing (Complete Metabolic Panel), blood typing, coagulation studies (PT/PTT/INR)
 - ii. Nutrient deficiency screening (vitamin B12, iron, folate) and formal nutrition evaluation by a registered dietician or nutritionist
 - iii. Cardiopulmonary risk evaluation - to assess as part of standard pre-operative clearance with EKG, Chest X-Ray, and echocardiogram as appropriate based on medical comorbidities
 - iv. GI evaluation - H. pylori screening in high-risk populations and assessment for necessity of cholecystectomy concurrent with surgery, if indicated
 - v. Endocrine evaluation - Hemoglobin A1c if diabetic, serum TSH if indicated at risk, and appropriate workup of endocrine abnormalities such as Cushing's disease for suspected reversible causes of obesity as part of history and physical
 - vi. Age appropriate cancer screening verified complete and up to date
 - vii. Smoking cessation counseling, if applicable
5. Psycho-social behavioral evaluation to determine ability to succeed and adhere to postoperative recommendations and long-term follow up and to identify any major mental health disorders that would contraindicate surgery and/or negatively impact patient compliance with postoperative follow-up care and adherence to nutrition guidelines.
 - a. No current substance abuse has been identified; *and*
 - b. Members who have any of the following conditions **MUST** have formal, documented preoperative psychological clearance:
 - i. A history of schizophrenia, borderline personality disorder, suicidal ideation, severe depression
 - ii. Who are currently under the care of a psychologist/psychiatrist
 - iii. Who are on psychotropic medications, as necessary in order to exclude members who are unable to provide informed consent or who are unable to comply with the pre- and postoperative regimen

Members with a BMI 30-34

Please review member plan coverage documents (e.g., Evidence of Coverage) as coverage indications may vary. In the *Standards of Medical Care in Diabetes – 2021 Obesity Management for the Treatment of Type 2 Diabetes*, American Diabetes Association recommends that metabolic surgery may be considered to treat type 2 diabetes in adults with BMI 30.0–34.9 kg/m² who do not achieve durable weight loss and improvement in comorbidities (including hyperglycemia) with nonsurgical methods (level A). Furthermore, in Asian Americans the BMI may be as low as 27.5 kg/m² to consider metabolic

surgery. In 2019 clinical practice guideline cosponsored by The American Society for Metabolic & Bariatric Surgery with other national societies, recommended Grade B for “patients with BMI 30 to 34.9 kg/m² and T2D with inadequate glycemic control despite optimal lifestyle and medical therapy should be considered for a bariatric procedure; current evidence is insufficient to support recommending a bariatric procedure in the absence of obesity.” A recent joint statement by international diabetes organizations concluded that the current scientific evidence supports a benefit to metabolic surgery in some patients with Class I obesity (BMI 30 - 34.9) who have poorly controlled type 2 diabetes despite optimal medical therapy. However, they also acknowledge continued knowledge limitations related to this population, in particular (a) the relatively modest number of these patients represented in randomized controlled trials to date, (b) the absence of head to head trials comparing the effectiveness of different types of procedures in this population, and (c) the lack of clear definition of what constitutes failure of optimal medical therapy. As a result, the Plan will consider the medical necessity of bariatric surgery in members with a BMI of 30 - 34.9 (same inclusion for the Asian American population), who continue to have poorly controlled type 2 diabetes despite adherence to optimal medical therapy on a case-by-case basis.

Repair, Replacement, Removal, Revision, or Conversion Procedures

Please refer to the member's plan documents for benefits

1. Repair is considered medically necessary when there is documentation of a surgical complication related to the original surgery, including:
 - a. Fistula
 - b. Erosion
 - c. Leakage of suture/staple line
 - d. Herniated band
 - e. Obstruction
 - f. Enlargement of the pouch due to complications of vomiting
 - i. **Note:** Enlargement of pouch (stretching) is NOT covered if due to overeating, as this is not a surgical complication and is therefore not considered medically necessary.
2. Replacement of an adjustable gastric band is considered medically necessary only if there are complications (e.g., port leakage, slippage) that cannot be corrected with band manipulation or adjustments.
3. Removal of an adjustable gastric band may be considered medically necessary when recommended by the member's physician.
4. Revision of a primary bariatric surgery is considered medically necessary when ALL of the following criteria are met:
 - a. The procedure has failed due to dilated gastrojejunal stoma, dilation of the anastomosis site, or dilation of the gastric pouch; *and*
 - b. The initial surgery successfully resulted in weight loss; *and*
 - c. The member has been compliant with the postoperative plan of diet, exercise, and behavioral modification.

5. Conversion surgery is performed in cases of inadequate weight loss when unrelated to surgical complications.
 - a. The Plan considers conversion of an adjustable gastric band to a sleeve gastrectomy, RYGB or BPD/DS medically necessary if there are complications that cannot be corrected with band manipulation or adjustments; *or*
 - b. The Plan considers conversion to a sleeve gastrectomy, RYGB or BPD/DS medically necessary when ALL of the following criteria are met:
 - i. Meets all medical necessity criteria for bariatric surgery as defined above; *and*
 - ii. Documented compliance with postoperative plan of diet, exercise, and behavioral modification; *and*
 - iii. A minimum of 2 years following original surgery with:
 1. Weight loss of less than 50% of preoperative *excess* body weight; *and*
 2. Remains >30% over ideal body weight; *or*
6. If the member is requesting conversion surgery from a sleeve gastrectomy to a Roux-en-Y gastric bypass for the indications of Proton Pump Inhibitor (PPI) Refractory Gastroesophageal Reflux Disease (GERD), Barrett's esophagus, or biopsy proven dysplasia, then the following criteria must be met:
 - a. A biopsy documented Barrett's esophagus with high grade dysplasia (cancer risk 7% per year) confirmed by two separate pathologists refractory to maximal medical and endoscopic therapy; *or*
 - b. A biopsy documented Barrett's esophagus with low grade dysplasia (cancer risk 0.7% per year) confirmed by two separate pathologists refractory to maximal medical therapy, including ALL of the following:
 - i. At least 3 months of prescription strength anti-secretory agents (e.g., omeprazole, pantoprazole, esomeprazole, etc.); *and*
 - ii. At least 3 months of one of the following (unless contraindicated):
 1. Aspirin, nonsteroidal anti-inflammatory agents, or statins (HMG-CoA reductase inhibitors); *and*
 - iii. Failure of endoscopic therapy; *or*
 - c. A biopsy proven non-dysplastic or indefinite grade dysplasia confirmed by two separate pathologists that has progressed to biopsy proven dysplasia despite at least 1 year of maximal medical therapy as described above; *or*
 - d. PPI Refractory Gastroesophageal Reflux Disease (GERD) by meeting the following indications:
 - i. Failure of at least 1 year of single dose prescription strength (not over the counter) anti-secretory treatment (e.g., PPI); *and*
 - ii. At least 8 weeks of dual prescription strength anti-secretory treatment (2 different PPIs taken together); *and*
 - iii. Biopsy proven erosive disease confirmed by two separate pathologists (e.g., esophagitis Los Angeles (LA) Grade C or D, peptic stricture requiring dilatation, Barrett's esophagus as described above); *and*

- iv. One of the following:
 1. Failure of endoscopic therapy; *or*
 2. Failure of prior surgical therapy (e.g., surgical fundoplication, hiatal hernia repair, vagotomy).

Experimental or Investigational / Not Medically Necessary

Procedures

The Plan considers the following procedures to be experimental, investigational or unproven as they have either not demonstrated long-term benefit, have unnecessary risks, or have demonstrated inferior outcomes to safer, more appropriate techniques:

- >150cm long limb gastric bypass (except for BPD with DS)
- Air-filled intragastric balloon or liquid-filled intragastric balloons (e.g., Orbera, ReShape)
- Aspiration therapy procedures
- Biliopancreatic Diversion without duodenal switch
- Conversion of Gastric Sleeve to Roux-en-Y Gastric Bypass for Gastroparesis
- Endoscopic sleeve gastropasty / endoluminal vertical gastropasty
- Gastric plication (Laparoscopic)
- Gastropasty (stomach stapling)
- Jejunioileal bypass
- Mini gastric bypass/one anastomosis gastric bypass/ Billroth II
- Natural orifice transoral surgery (NOTES)
- Open adjustable gastric banding
- Prophylactic mesh placement to prevent incisional hernia after open bariatric surgery
- Silastic ring (Fobi pouch)
- Vagal blockade (Vagus Nerve Blocking Therapy)
- Vertical Banded Gastropasty (VBG)

Skin Removal Surgery

Excess skin is common after a successful bariatric surgery. Unless MCG criteria is met, skin removal by abdominoplasty and/or panniculectomy is considered a cosmetic and elective procedure that is not medically necessary by the Plan.

Relative Contraindications

General

- Medically correctable cause of obesity
- Severe or unstable cardiovascular disease
- Severe coagulopathy
- Severe pulmonary disease
- Cirrhosis with portal hypertension
- Ongoing substance abuse or substance abuse in preceding 12 months
- Severe or poorly controlled psychiatric disorder or mental illness

- Medical, psychological, psychosocial, or cognitive condition that prevents adherence to post-op dietary and medical requirements or impairs decision capacity
- Non-compliance with dietary restrictions
- Bulimia nervosa
- Current or planned pregnancy within 12-18 months
- Advanced stage neoplastic disease

Laparoscopic Adjustable Gastric Banding

- Inflammatory bowel disease
- Potential upper GI bleeding such as esophageal or gastric varices
- Congenital or acquired malformations of the GI tract such as stenoses or atresias
- Intra-operative gastric injury during the implantation procedure
- Chronic pancreatitis
- Cirrhosis
- Portal hypertension
- Any infection, bacteremia, or sepsis
- Chronic, long-term use of steroids
- Systemic inflammatory or autoimmune condition such as scleroderma and systemic lupus erythematosus

Malabsorptive Procedures (Roux-en-Y and Biliopancreatic Bypass with Duodenal Switch)

- Inflammatory bowel disease
- Critical need to maintain drug levels, such as in seizure or psychiatric illness, where malabsorption or changes in drug metabolism may result in serious consequences

Applicable Billing Codes (HCPCS & CPT Codes)

Codes considered medically necessary if clinical criteria are met:

<i>Code</i>	<i>Description</i>
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
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components) [not medically necessary if history of prior Roux-en-Y gastric bypass or sleeve gastrectomy] [not medically necessary with gastric plication]
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)
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
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
47562 - 47579, - 47600 - 47620	Cholecystectomy
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline
S9449	Weight management classes, non-physician provider, per session
S9451	Exercise classes, non-physician provider, per session
S9452	Nutrition classes, non-physician provider, per session
ICD-10 codes considered medically necessary if criteria are met:	
<i>Code</i>	<i>Description</i>
E66.01	Morbid (severe) obesity due to excess calories

E66.2	Morbid (severe) obesity with alveolar hypoventilation
Z68.30	Body mass index [BMI]30.0-30.9, adult
Z68.31	Body mass index [BMI] 31.0-31.9, adult
Z68.32	Body mass index [BMI] 32.0-32.9, adult
Z68.33	Body mass index [BMI] 33.0-33.9, adult
Z68.34	Body mass index [BMI] 34.0-34.9, adult
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) 50.0-59.9, adult
Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.45	Body mass index (BMI) 70 or greater, adult

For requests related to conversion surgery from a sleeve gastrectomy to a Roux-en-Y gastric bypass, the following codes may apply as medically necessary:

<i>Code</i>	<i>Description</i>
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)

For requests related to conversion surgery from a sleeve gastrectomy to a Roux-en-Y gastric bypass, the following codes would NOT be medically necessary:

<i>Code</i>	<i>Description</i>
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh

43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh
43620	Gastrectomy, total; with esophagoenterostomy
43621	Gastrectomy, total; with Roux-en-Y reconstruction
43632	Gastrectomy, partial, distal; with gastrojejunostomy
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction
43634	Gastrectomy, partial, distal; with formation of intestinal pouch
43820	Gastrojejunostomy; without vagotomy
43825	Gastrojejunostomy; with vagotomy, any type

Codes not indicated in this Guideline:

<i>Code</i>	<i>Description</i>
0312T	Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming
0313T	Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator
0314T	Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator
0315T	Vagus nerve blocking therapy (morbid obesity); removal of pulse generator
0316T	Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator
0317T	Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed
15876 - 15879	Suction assisted lipectomy; head and neck, trunk, upper/lower extremities
43620	Gastrectomy, total; with esophagoenterostomy
43621	Gastrectomy, total; with Roux-en-Y reconstruction
43622	Gastrectomy, total; with formation of intestinal pouch, any type

43631	Gastrectomy, partial, distal; with gastroduodenostomy
43632	Gastrectomy, partial distal; with gastrojejunostomy (Billroth II) [when specified as bariatric surgery]
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction
43634	Gastrectomy, partial, distal; with formation of intestinal pouch
43635	Vagotomy when performed with partial distal gastrectomy (List separately in addition to code(s) for primary procedure)
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43659	Unlisted laparoscopy procedure, stomach [when specified as gastric plication (laparoscopic greater curvature plication [LGCP]) with or without gastric banding, or mini-gastric bypass procedure]
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
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open
43999	Unlisted procedure, stomach [when specified as endoluminal gastric restrictive surgery or placement of intragastric balloon device]

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