



Medical Policy

Medical and Surgical Management of Obesity including Anorexiant

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Policy Number: 379

BCBSA Reference Number: 7.01.47

NCD/LCD:

National Coverage Determination (NCD) for Intensive Behavioral Therapy for Obesity (210.12)

National Coverage Determination (NCD) for Bariatric Surgery for the Treatment of Morbid Obesity (100.1)

Related Policies

Gastric Electrical Stimulation, #[636](#)

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Surgical Management of Obesity Services Preauthorization Request Form

Providers please complete the form. [Click here for the Surgical Management of Obesity Services preauthorization request form \(#047\).](#)

The following bariatric surgeries may be considered **MEDICALLY NECESSARY** for obesity that has not responded to conservative measures in patients who meet the “Patient Selection Criteria” described in this policy:

1. Bariatric Surgery in Adults with Morbid Obesity

The following bariatric surgery services may be considered **MEDICALLY NECESSARY** for the treatment of morbid obesity in adults who have failed weight loss by conservative measures. Bariatric surgery should be performed in appropriately selected patients, by surgeons who are adequately trained and experienced in the specific techniques used, and in institutions that support a comprehensive bariatric surgery program, including long-term monitoring and follow-up post-surgery.

- Open gastric bypass using a Roux-en-Y anastomosis
- Laparoscopic gastric bypass using a Roux-en-Y anastomosis
- Laparoscopic adjustable gastric banding
- Sleeve gastrectomy
- Open or laparoscopic biliopancreatic bypass (i.e., the Scopinaro procedure) with duodenal switch.

Patient Selection Criteria

Adults over the age of 18 or who have documented complete bone growth are eligible for obesity surgery if **ALL** of the following criteria are met:

- The physician has indicated that the patient:
 - Is a well informed and motivated patient with acceptable operative risks, AND
 - Has a strong desire for substantial weight loss, AND
 - Has failed other non-surgical approaches to long-term weight loss, AND
 - Is enrolled in a program which provides pre-op and post-op multidisciplinary evaluation and care including: behavioral health, nutrition, and medical management AND
- The patient is morbidly obese with a BMI > 40kg/m².

OR

- The patient has a BMI >35kg/m² and the physician has indicated that the patient has one or more of the following high risk co-morbid conditions:
 - Sleep apnea
 - Pickwickian syndrome
 - Pseudotumor cerebri
 - Obesity related cardiomyopathy
 - Type II Diabetes
 - At least Stage 1 Hypertension based on JNC-VII (SBP >140 and/or DBP >90) after combination pharmacotherapy
 - Coronary artery disease, or
 - Obesity related pulmonary hypertension.

The following bariatric surgeries are considered **INVESTIGATIONAL** for managed care (HMO and POS), PPO, and Indemnity members:

- Vertical-banded gastroplasty,
- Gastric bypass using a Billroth II type of anastomosis (mini-gastric bypass),
- Biliopancreatic bypass without duodenal switch,
- Long limb gastric bypass (i.e., >150 cm),
- Two-stage bariatric surgery procedures (e.g., sleeve gastrectomy as initial procedure followed by biliopancreatic diversion at a later time),
- Endoscopic procedures (e.g., insertion of the StomaphyX™ device, EndoCinch suturing system) as a primary bariatric procedure or as a revision procedure, (i.e., to treat weight gain after bariatric surgery to remedy large gastric stoma or large gastric pouches),
- Jejunioileal bypass,
- Horizontal gastric partitioning/ gastroplasty,
- Gastric wrapping,
- Garren-Edwards gastric bubble,
- Gastric Electric Stimulation for the treatment of obesity (Gastric pacemaker), and Any bariatric surgery performed as a cure for type 2 diabetes mellitus
- Laparoscopic gastric plication.

2. Bariatric Surgery in Patients with a BMI Less Than 35 kg/m²

Bariatric surgery is considered **NOT MEDICALLY NECESSARY** for patients with a BMI less than 35 kg/m².

3. Bariatric Surgery in Adolescents

Bariatric surgery in adolescents may be considered **MEDICALLY NECESSARY** according to the same weight-based criteria used for adults, but greater consideration should be given to psychosocial and informed consent issues. Patients must meet the "Patient Selection Criteria" described in this policy. In addition, any devices used for bariatric surgery must be in accordance with the FDA-approved indications for use.

4. Concomitant Hiatal Hernia Repair with Bariatric Surgery

Repair of a hiatal hernia at the time of bariatric surgery may be considered **MEDICALLY NECESSARY** for patients who have a preoperatively-diagnosed hiatal hernia with indications for surgical repair.

The Society of American Gastrointestinal and Endoscopic Surgeons have issued evidence-based guidelines for the management of hiatal hernia. Recommendations for indications for repair are as follows:

- Repair of a type I hernia [sliding hiatal hernias, where the gastroesophageal junction migrates above the diaphragm] in the absence of reflux disease is not necessary (moderate quality evidence, strong recommendation).
- All symptomatic paraesophageal hiatal hernias should be repaired (high quality evidence, strong recommendation), particularly those with acute obstructive symptoms or which have undergone volvulus.
- Routine elective repair of completely asymptomatic paraesophageal hernias may now always be indicated. Consideration for surgery should include the patient's age and comorbidities (moderate quality evidence, weak recommendation).

Repair of a hiatal hernia that is diagnosed at the time of bariatric surgery, or repair of a preoperatively diagnosed hiatal hernia in patients who do not have indications for surgical repair, is considered **INVESTIGATIONAL**.

The physician-directed visits and testing aspects of multi-faceted dietary programs such as Health Management Resources may be considered **MEDICALLY NECESSARY**.

Non-physician directed and food replacement or supplement components of multi-faceted dietary programs such as Health Management Resources are considered **NOT MEDICALLY NECESSARY**.

The following medical and pharmaceutical treatments for obesity are considered **NOT MEDICALLY NECESSARY**:

- Multi-faceted dietary programs such as Optifast, and Medifast
- Orlistat [™] (Xenical [®]) because it may be purchased over the counter (alli [™]) without a prescription.
- Anorexiant and/or drugs to promote weight loss.

Medicare HMO BlueSM and Medicare PPO BlueSM Members

For procedures not listed below, please follow the above medical necessity criteria as outlined for Commercial plans.

Intensive Behavioral Therapy for Obesity

Indications and Limitations of Coverage

Effective for claims with dates of service on or after November 29, 2011, CMS covers intensive behavioral therapy for obesity, defined as a body mass index (BMI) ≥ 30 kg/m², for the prevention or early detection of illness or disability.

Intensive behavioral therapy for obesity consists of the following:

1. Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m²);
2. Dietary (nutritional) assessment; and
3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

National Coverage Determination (NCD) for Intensive Behavioral Therapy for Obesity (210.12)

<http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=353&ncdver=1&bc=AgAAgAAAAAAAAA%3d%3d&>

Bariatric Surgery for the Treatment of Morbid Obesity

Indications and Limitations of Coverage

Effective for services performed on and after February 21, 2006, Open and laparoscopic Roux-en-Y gastric bypass (RYGBP), open and laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS), and laparoscopic adjustable gastric banding (LAGB) are covered for Medicare beneficiaries who have a body-mass index > 35, have at least one co-morbidity related to obesity, and have been previously unsuccessful with medical treatment for obesity.

These procedures are only covered when performed at facilities that are: (1) certified by the American College of Surgeons as a Level 1 Bariatric Surgery Center (program standards and requirements in effect on February 15, 2006); or (2) certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (program standards and requirements in effect on February 15, 2006).

Effective for services performed on and after February 12, 2009, the Centers for Medicare & Medicaid Services (CMS) determines that Type 2 diabetes mellitus is a co-morbidity for purposes of this NCD. A list of approved facilities and their approval dates are listed and maintained on the CMS Coverage Web site at <http://www.cms.hhs.gov/center/coverage.asp>, and published in the Federal Register.

Nationally Non-Covered Indications

The following bariatric surgery procedures are non-covered for all Medicare beneficiaries:

Open adjustable gastric banding;

Open sleeve gastrectomy; and,

Laparoscopic sleeve gastrectomy (prior to June 27, 2012)

Open and laparoscopic vertical banded gastroplasty

The two previous non-coverage determinations remain unchanged - Gastric Balloon (Section 100.11) and Intestinal Bypass (Section 100.8).

Other

Effective for services performed on and 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.

National Coverage Determination (NCD) for Bariatric Surgery for the Treatment of Morbid Obesity (100.1)

<http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=57&ncdver=4&DocID=100.1&bc=gAAAAAgAAAAAA%3d%3d&>

Prior Authorization Information

Pre-service approval is required for all inpatient services for all products.

See below for situations where prior authorization may be required or may not be required.

Yes indicates that prior authorization is required.

No indicates that prior authorization is not required.

N/A indicates that this service is primarily performed in an inpatient setting.

Outpatient

Commercial Managed Care (HMO and POS)	Yes for surgical services No for medical services
Commercial PPO and Indemnity	No for surgical services No for medical services
Medicare HMO BlueSM	Yes for surgical services No for medical services
Medicare PPO BlueSM	No for surgical services No for medical services

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CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

CPT Codes

CPT codes:	Code Description
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band 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
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)

ICD-9 Procedure Codes

ICD-9-CM procedure codes:	Code Description
43.82	Laparoscopic vertical (sleeve) gastrectomy
43.89	Open and other partial gastrectomy
44.31	High gastric bypass
44.38	Laparoscopic gastroenterostomy
44.39	Other gastroenterostomy without gastrectomy
44.5	Revision of gastric anastomosis
44.68	Laparoscopic gastropasty
44.69	Other repair of stomach
44.95	Laparoscopic gastric restrictive procedure
45.51	Isolation of segment of small intestine
45.91	Small-to-small intestinal anastomosis
46.79	Other repair of intestine

ICD-10 Procedure Codes

ICD-10-PCS procedure codes:	Code Description
0DB64Z3	Excision of Stomach, Percutaneous Endoscopic Approach, Vertical

0D160ZA	Bypass Stomach to Jejunum, Open Approach
0D160ZB	Bypass Stomach to Ileum, Open Approach
0D164ZA	Bypass Stomach to Jejunum, Percutaneous Endoscopic Approach
0D164ZB	Bypass Stomach to Ileum, Percutaneous Endoscopic Approach
0D190ZB	Bypass Duodenum to Ileum, Open Approach
0D194ZB	Bypass Duodenum to Ileum, Percutaneous Endoscopic Approach
0DB60Z3	Excision of Stomach, Open Approach, Vertical
0DB60ZZ	Excision of Stomach, Open Approach
0DB80ZZ	Excision of Small Intestine, Open Approach
0DB90ZZ	Excision of Duodenum, Open Approach
0DBB0ZZ	Excision of Ileum, Open Approach
0DM60ZZ	Reattachment of Stomach, Open Approach
0DM64ZZ	Reattachment of Stomach, Percutaneous Endoscopic Approach
0DM80ZZ	Reattachment of Small Intestine, Open Approach
0DM84ZZ	Reattachment of Small Intestine, Percutaneous Endoscopic Approach
0DM90ZZ	Reattachment of Duodenum, Open Approach
0DM94ZZ	Reattachment of Duodenum, Percutaneous Endoscopic Approach
0DMA0ZZ	Reattachment of Jejunum, Open Approach
0DMA4ZZ	Reattachment of Jejunum, Percutaneous Endoscopic Approach
0DMB0ZZ	Reattachment of Ileum, Open Approach
0DMB4ZZ	Reattachment of Ileum, Percutaneous Endoscopic Approach
0DQ60ZZ	Repair Stomach, Open Approach
0DQ64ZZ	Repair Stomach, Percutaneous Endoscopic Approach
0DQ80ZZ	Repair Small Intestine, Open Approach
0DQ84ZZ	Repair Small Intestine, Percutaneous Endoscopic Approach
0DQ90ZZ	Repair Duodenum, Open Approach
0DQ94ZZ	Repair Duodenum, Percutaneous Endoscopic Approach
0DQA0ZZ	Repair Jejunum, Open Approach
0DQA4ZZ	Repair Jejunum, Percutaneous Endoscopic Approach
0DQB0ZZ	Repair Ileum, Open Approach
0DQB4ZZ	Repair Ileum, Percutaneous Endoscopic Approach
0DV60CZ	Restriction of Stomach with Extraluminal Device, Open Approach
0DV64CZ	Restriction of Stomach with Extraluminal Device, Percutaneous Endoscopic Approach

The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT and/or ICD Procedure Codes above if medical necessity criteria are met:

ICD-9 Diagnosis Codes

ICD-9-CM diagnosis codes:	Code Description
278.01	Morbid obesity
V85.35	Body Mass Index 35.0-35.9, adult
V85.36	Body Mass Index 36.0-36.9, adult
V85.37	Body Mass Index 37.0-37.9, adult
V85.38	Body Mass Index 38.0-38.9, adult
V85.39	Body Mass Index 39.0-39.9, adult
V85.41	Body Mass Index 40.0-44.9, adult
V85.42	Body Mass Index 45.0-49.9, adult
V85.43	Body Mass Index 50.0-59.9, adult
V85.44	Body Mass Index 60.0-69.9, adult
V85.45	Body Mass Index 70 and over, adult

ICD-10 Diagnosis Codes

ICD-10-CM Diagnosis codes:	Code Description
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

The following CPT codes are considered investigational for **Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:**

CPT Codes

CPT codes:	Code Description
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
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
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption

Description

Bariatric surgery is performed for the treatment of morbid (clinically severe) obesity. Morbid obesity is defined as a BMI greater than 40 kg/m² or a BMI greater than 35 kg/m² with associated complications including, but not limited to, diabetes, hypertension, or obstructive sleep apnea. Morbid obesity results in a very high risk for weight-related complications, such as diabetes, hypertension, obstructive sleep apnea, and various types of cancers (for men: colon, rectum, prostate; for women: breast, uterus, ovaries), and a shortened life span. A morbidly obese man at age 20 can expect to live 13 fewer years than his counterpart with a normal BMI, which equates to a 22% reduction in life expectancy.

The first treatment of morbid obesity is dietary and lifestyle changes. Although this strategy may be effective in some patients, only a few morbidly obese individuals can reduce and control weight through diet and exercise. Most patients find it difficult to comply with these lifestyle modifications on a long-term basis.

When conservative measures fail, some patients may consider surgical approaches. A 1991 National Institutes of Health Consensus Conference defined surgical candidates as “those patients with a BMI of greater than 40 kg/m², or greater than 35 kg/m² in conjunction with severe comorbidities such as cardiopulmonary complications or severe diabetes.” (See the Policy Guidelines section on how to calculate BMI.)

Resolution (cure) or improvement of type 2 diabetes mellitus (T2DM) after bariatric surgery and observations that glycemic control may improve immediately after surgery, before a significant amount of weight is lost, have promoted interest in a surgical approach to treatment of T2DM. The various surgical

procedures have different effects, and gastrointestinal rearrangement seems to confer additional anti-diabetic benefits independent of weight loss and caloric restriction. The precise mechanisms are not clear, and multiple mechanisms may be involved. Gastrointestinal peptides, glucagon-like peptide-1 (1GLP-1), glucose-dependent insulinotropic peptide (GIP), and peptide YY (PYY) are secreted in response to contact with unabsorbed nutrients and by vagally mediated parasympathetic neural mechanisms. GLP-1 is secreted by the L cells of the distal ileum in response to ingested nutrients and acts on pancreatic islets to augment glucose-dependent insulin secretion. It also slows gastric emptying, which delays digestion, blunts postprandial glycemia, and acts on the central nervous system to induce satiety and decrease food intake. Other effects may improve insulin sensitivity. GIP acts on pancreatic beta cells to increase insulin secretion through the same mechanisms as GLP-1, although it is less potent. PYY is also secreted by the L cells of the distal intestine and increases satiety and delays gastric emptying.

The following summarizes the different types of bariatric surgery procedures.

1. Vertical-Banded Gastroplasty (CPT code 43842)

Vertical-banded gastroplasty was formerly one of the most common gastric restrictive procedures performed in the United States, but has now been essentially replaced by other restrictive procedures due to high rates of revisions and reoperations. In this procedure, the stomach is segmented along its vertical axis. To create a durable reinforced and rate-limiting stoma at the distal end of the pouch, a plug of stomach is removed, and a propylene collar is placed through this hole and then stapled to itself. Because the normal flow of food is preserved, metabolic complications are uncommon. Complications include esophageal reflux, dilation, or obstruction of the stoma, with the latter 2 requiring reoperation. Dilation of the stoma is a common reason for weight regain. Vertical-banded gastroplasty may be performed using an open or laparoscopic approach.

2. Adjustable Gastric Banding (CPT code 43770—laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device [eg, gastric band and subcutaneous port components])

Adjustable gastric banding involves placing a gastric band around the exterior of the stomach. The band is attached to a reservoir that is implanted subcutaneously in the rectus sheath. Injecting the reservoir with saline will alter the diameter of the gastric band; therefore, the rate-limiting stoma in the stomach can be progressively narrowed to induce greater weight loss, or expanded if complications develop. Because the stomach is not entered, the surgery and any revisions, if necessary, are relatively simple. Complications include slippage of the external band or band erosion through the gastric wall. Adjustable gastric banding has been widely used in Europe. Two such devices are approved by FDA for marketing in the United States. The first such device that received FDA approval was the LAP-BAND (original applicant, Allergan Inc., BioEnterics, Carpinteria, CA; sold to Apollo Endosurgery Inc., Austin, TX, in 2013). The labeled indications for this device are as follows:

"The LAP-BAND® system is indicated for use in weight reduction for severely obese patients with a body mass index (BMI) of at least 40 or a BMI of at least 35 with one or more severe comorbid conditions, or those who are 100 lb or more over their estimated ideal weight according to the 1983 Metropolitan Life Insurance Tables (use the midpoint for medium frame). It is indicated for use only in severely obese adult patients who have failed more conservative weight-reduction alternatives, such as supervised diet, exercise and behavior modification programs. Patients who elect to have this surgery must make the commitment to accept significant changes in their eating habits for the rest of their lives."

In 2011, FDA-labelled indications for the LAP-BAND were expanded to include patients with a BMI from 30 to 34 with at least 1 obesity-related comorbid condition.

A second adjustable gastric banding device was approved by FDA through the premarket approval (PMA) process in September 2007, the REALIZE® model (Ethicon Endo-Surgery, Cincinnati, OH). Labeled indications for this device are as listed next:

"The [REALIZE] device is indicated for weight reduction for morbidly obese patients and is indicated for individuals with a BMI of at least 40 kg/m², or a BMI of at least 35 kg/m² with one or more comorbid conditions. The band is indicated for use only in morbidly obese adult patients who have failed more

conservative weight-reduction alternatives, such as supervised diet, exercise, and behavior modification programs.”

3. Open Gastric Bypass (CPT code 43846—gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb [150 cm or less] Roux-en-Y gastroenterostomy)

The original gastric bypass surgeries were based on the observation that postgastrectomy patients tended to lose weight. The current procedure involves both a restrictive and a malabsorptive component, with horizontal or vertical partition of the stomach performed in association with a Roux-en-Y procedure (ie, a gastrojejunal anastomosis). Thus, the flow of food bypasses the duodenum and proximal small bowel. The procedure may also be associated with an unpleasant “dumping syndrome,” in which a large osmotic load delivered directly to the jejunum from the stomach produces abdominal pain and/or vomiting. The dumping syndrome may further reduce intake, particularly in “sweets eaters.” Operative complications include leakage and marginal ulceration at the anastomotic site. Because the normal flow of food is disrupted, there are more metabolic complications compared with other gastric restrictive procedures, including iron deficiency anemia, vitamin B₁₂ deficiency, and hypocalcemia, all of which can be corrected by oral supplementation. Another concern is the ability to evaluate the “blind” bypassed portion of the stomach. Gastric bypass may be performed with either an open or laparoscopic technique.

Note: In 2005, the CPT code 43846 was revised to indicate that the short limb must be 150 cm or less, compared with the previous 100 cm. This change reflects the common practice in which the alimentary (ie, jejunal limb) of a gastric bypass has been lengthened to 150 cm. This length also serves to distinguish a standard gastric bypass with a very long, or very, very long gastric bypass, as discussed further here.

4. Laparoscopic Gastric Bypass (CPT code 43644—laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy [Roux limb 150 cm or less])

CPT code 43644 was introduced in 2005 and essentially described the same procedure as No. 3, but performed laparoscopically.

5. Mini-Gastric Bypass (no specific CPT code)

Recently, a variant of the gastric bypass, called the mini-gastric bypass, has been popularized. Using a laparoscopic approach, the stomach is segmented, similar to a traditional gastric bypass, but instead of creating a Roux-en-Y anastomosis, the jejunum is anastomosed directly to the stomach, similar to a Billroth II procedure. This unique aspect of this procedure is not based on its laparoscopic approach but rather the type of anastomosis used. It should also be noted that CPT code 43846 explicitly describes a Roux-en-Y gastroenterostomy, which is not used in the mini-gastric bypass.

6. Sleeve Gastrectomy (CPT code 43775 – laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy [ie, sleeve gastrectomy])

A sleeve gastrectomy is an alternative approach to gastrectomy that can be performed on its own or in combination with malabsorptive procedures (most commonly biliopancreatic diversion with duodenal switch). In this procedure, the greater curvature of the stomach is resected from the angle of His to the distal antrum, resulting in a stomach remnant shaped like a tube or sleeve. The pyloric sphincter is preserved, resulting in a more physiologic transit of food from the stomach to the duodenum and avoiding the dumping syndrome (overly rapid transport of food through stomach into intestines) that is seen with distal gastrectomy. This procedure is relatively simple to perform and can be done as an open or laparoscopic procedure. Some surgeons have proposed the sleeve gastrectomy as the first in a 2-stage procedure for very high-risk patients. Weight loss following sleeve gastrectomy may improve a patient's overall medical status and thus, reduce the risk of a subsequent more extensive malabsorptive procedure, such as biliopancreatic diversion.

7. Endoluminal (also called endosurgical, endoscopic, or natural orifice) bariatric procedures (no specific CPT code)

With these procedures, access to the relevant anatomic structures is gained through the mouth without skin incisions. Primary and revision bariatric procedures are being developed to reduce the risks associated with open and laparoscopic interventions. Examples of endoluminal bariatric procedures

studies include gastropasty using a transoral endoscopically guided stapler and placement of devices such as a duodenojejunal sleeve and gastric balloon.

8. Biliopancreatic Bypass Procedure (also known as the Scopinaro procedure) (CPT code 43847—gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption)

Biliopancreatic bypass (BPB) procedure, developed and used extensively in Italy, was designed to address some of the drawbacks of the original intestinal bypass procedures that have been abandoned due to unacceptable metabolic complications. Many of the complications were thought to be related to bacterial overgrowth and toxin production in the blind, bypassed segment. In contrast, BPB consists of a subtotal gastrectomy and diversion of the biliopancreatic juices into the distal ileum by a long Roux-en-Y procedure. The procedure consists of the following components.

- a. A distal gastrectomy induces a temporary early satiety and/or the dumping syndrome in the early postoperative period, both of which limit food intake.
- b. A 200-cm long “alimentary tract” consists of 200 cm of ileum connecting the stomach to a common distal segment.
- c. A 300- to 400-cm “biliary tract” connects the duodenum, jejunum, and remaining ileum to the common distal segment.
- d. A 50- to 100-cm “common tract” is where food from the alimentary tract mixes with biliopancreatic juices from the biliary tract. Food digestion and absorption, particularly of fats and starches, are therefore limited to this small segment of bowel, ie, creating a selective malabsorption. The length of the common segment will influence the degree of malabsorption.
- e. Because of the high incidence of cholelithiasis associated with the procedure, patients typically undergo an associated cholecystectomy.

Many potential metabolic complications are related to biliopancreatic bypass, including most prominently, iron deficiency anemia, protein malnutrition, hypocalcemia, and bone demineralization. Protein malnutrition may require treatment with total parenteral nutrition. In addition, there have been several case reports of liver failure resulting in death or liver transplant.

9. Biliopancreatic Bypass With Duodenal Switch (CPT code 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])

CPT code 43845, which specifically identifies the duodenal switch procedure, was introduced in 2005. The duodenal switch procedure is essentially a variant of the biliopancreatic bypass previously described. In this procedure, instead of performing a distal gastrectomy, a sleeve gastrectomy is performed along the vertical axis of the stomach. This approach preserves the pylorus and initial segment of the duodenum, which is then anastomosed to a segment of the ileum, similar to the biliopancreatic bypass, to create the alimentary limb. Preservation of the pyloric sphincter is intended to ameliorate the dumping syndrome and decrease the incidence of ulcers at the duodenoileal anastomosis by providing a more physiologic transfer of stomach contents to the duodenum. The sleeve gastrectomy also decreases the volume of the stomach and decreases the parietal cell mass. However, the basic principle of the procedure is similar to that of the biliopancreatic bypass, ie, producing selective malabsorption by limiting the food digestion and absorption to a short common ileal segment.

10. Long-Limb Gastric Bypass (ie, >150 cm) (CPT code 43847—Gastric restrictive procedure with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption)

Recently, variations of gastric bypass procedures have been described, consisting primarily of long-limb Roux-en-Y procedures, which vary in the length of the alimentary and common limbs. For example, the stomach may be divided with a long segment of the jejunum (instead of ileum) anastomosed to the proximal gastric stump, creating the alimentary limb. The remaining pancreaticobiliary limb, consisting of stomach remnant, duodenum, and length of proximal jejunum, is then anastomosed to the ileum, creating a common limb of variable length in which the ingested food mixes with the pancreaticobiliary juices. While the long alimentary limb permits absorption of most nutrients, the short common limb primarily limits absorption of fats. The stomach may be bypassed in a variety of ways, ie, either by resection or stapling along the horizontal or vertical axis. Unlike the traditional gastric bypass, which is essentially a gastric restrictive procedure, these very long-limb Roux-en-Y gastric bypasses combine gastric restriction with

some element of malabsorptive procedure, depending on the location of the anastomoses. Note that CPT code for gastric bypass (43846) explicitly describes a short limb (<150 cm) Roux-en-Y gastroenterostomy, and thus would not apply to long-limb gastric bypass.

11. Laparoscopic Malabsorptive Procedure (CPT code 43645—Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption)

CPT code 43645 was introduced in 2005 to specifically describe a laparoscopic malabsorptive procedure. However, the code does not specifically describe any specific malabsorptive procedure.

12. Laparoscopic Gastric Plication (no specific CPT code)

Laparoscopic gastric plication is a bariatric surgery procedure that involves laparoscopic placement of sutures over the greater curvature (laparoscopic greater curvature plication) or anterior gastric region (laparoscopic anterior curvature plication) to create a tube-like stomach. The procedure involves 2 main steps, mobilization of the greater curvature of the stomach and suture plication of the stomach for achieving gastric restriction, but specifics of the technique are not standardized.

Summary

Bariatric surgery is a treatment for morbid obesity in patients who fail to lose weight with conservative measures. There are numerous different surgical techniques available. These different techniques have heterogenous mechanisms of action, with varying degrees of gastric restriction that creates a small gastric pouch, malabsorption of nutrients, and metabolic changes that result from gastric and intestinal surgery.

There is a very large body of literature on bariatric surgery, but few high-quality randomized controlled trials (RCTs). The available evidence, largely from nonrandomized comparative studies and case series, supports the conclusion that bariatric surgery results in greater weight loss and improvements in weight-related comorbidity compared with nonsurgical treatments. Gastric bypass, performed by either the open or laparoscopic approach, improves health outcomes of morbidly obese patients by leading to substantial weight loss with relatively low rates of adverse events (AEs). Gastric bypass accounts for more than 80% of bariatric operations performed in the United States and is considered the reference standard to which other procedures should be compared. There is also sufficient evidence that laparoscopic gastric banding, sleeve gastrectomy, and biliopancreatic diversion with duodenal switch improve outcomes. For these procedures compared with gastric bypass, there is a tradeoff in terms of the amount of weight loss, short-term complications, and long-term complications. An informed choice between patients and surgeons should be made after a thorough consideration of the risks and benefits of each procedure. Other bariatric surgery procedures remain investigational, as listed in the policy statement.

Limited evidence is available on bariatric surgery in patients with a body mass index (BMI) of less than 35 kg/m². Case series report a high rate of remission of diabetes in undergoing gastric bypass surgery, and this indication was judged to meet the TEC criteria in 2012. However, bariatric surgery for diabetes in patients with a BMI less than 35 is not currently considered standard of care and is not supported in current specialty society guidelines. For patients without diabetes, there is limited evidence on outcomes of surgery and no evidence that health outcomes are improved. As a result, bariatric surgery for patients with a BMI less than 35 is considered not medically necessary.

Bariatric surgery for adolescents is considered medically necessary using the same indications as for adults. However, greater consideration should be placed on the development stage of the patient, the psychosocial aspects of obesity and surgery, and on ensuring that the patient is able to provide fully informed consent.

Limited evidence is available related to the repair of hiatal hernias at the time of bariatric surgery. Studies suggest that such repair is feasible and does not significantly increase perioperative complications. However, the evidence is not sufficient to allow conclusions about whether repair of hiatal hernias, either diagnosed at surgery or preoperatively, improves outcomes for patients who are undergoing bariatric

surgery. Therefore, the repair of incidentally diagnosed hiatal hernia at the time of bariatric surgery repair is considered investigational.

To achieve optimal outcomes following bariatric surgery, similar to those reported in the literature from large bariatric surgery centers, certain conditions should be met. Careful patient selection and thorough preoperative screening are essential. Surgeons need to be adequately trained in the particular techniques and should perform a high volume of these procedures. The institution should provide a full range of ancillary services, such as nursing and psychological support, and should provide for life-long follow-up after surgery. These conditions are best attainable as part of a dedicated, comprehensive bariatric surgery program that focuses on multidisciplinary care of the bariatric surgery patient.

Policy History

Date	Action
3/2016	Policy statement removed: Medical management of obesity may be medically necessary including laboratory services and other diagnostic tests prescribed by the physician specialist, and nutritional counseling in accordance with the member's subscriber certificate. Clarified coding information. Effective 3/1/2016.
1/2016	Prior authorization information clarified. 1/1/2016.
10/2015	Clarified coding information.
6/2015	Medically necessary statements on revision bariatric surgery retired. Coding information clarified. Effective 6/1/2015.
3/2015	BCBSA National medical policy review. New medically necessary and investigational indications described. Statement on bariatric surgery in patients with BMI <35 changed from investigational to not medically necessary. Effective 3/1/2015.
10/2014	Language on Health Management Resources clarified.
9/2014	Clarified coding information. Surgical Management of Obesity Services Preauthorization Request Form transferred to #047.
6/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
3/2014	BCBSA National medical policy review. Language added to policy statement on revision surgery to include complications of laparoscopic adjustable gastric banding. Effective 3/1/2014.
11/2013	Removed facility certification requirement for coverage of covered bariatric surgery procedures for Medicare Advantage. Effective 9/24/2013.
4/2013	Added coverage for stand-alone laparoscopic sleeve gastrectomy for Medicare HMO Blue and Medicare PPO Blue members. Retroactive to June 27, 2012.
4/2013	BCBSA National medical policy review. Changes to policy statement. Effective 4/1/2013.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
1/2012	BCBSA National medical policy review. Changes to policy statements.
5/2011	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
11/2010	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
11/2010	BCBSA National medical policy review. Changes to policy statements.
2/2010	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
11/2009	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
3/2010	Review of Medicare NCD.

	Changes to policy statement.
11/2009	BCBSA National medical policy review. Changes to policy statements.
2/2009	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
11/2008	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
9/2008	BCBSA National medical policy review. Changes to policy statements.
4/2008	BCBSA National medical policy review. Changes to policy statements.
2/2008	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
5/2007	BCBSA National medical policy review. Changes to policy statements.
2/2007	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
5/1996	New policy, effective 5/1996, describing covered and non-covered indications.

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