Bariatric Surgery
Corporate Medical Policy

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File code: UM.SURG.01
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Description

Surgery for morbid obesity, termed bariatric surgery, falls into two general categories: 1) gastric-restrictive procedures that create a small gastric pouch, resulting in weight loss by producing early satiety and thus decreasing dietary intake; and 2) malabsorptive procedures, which produce weight loss due to malabsorption by altering the normal transit of ingested food through the gastrointestinal tract. Some bariatric procedures may include both a restrictive and a malabsorptive component.

Bariatric surgery is performed for the treatment of morbid (clinically severe) obesity. Morbid obesity is defined as a body mass index (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, and prostate; for women: breast, uterus, and ovaries), and a shortened life span. A morbidly obese man at age 20 can expect to live 13 years less 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. The majority of 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 (NIH) 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 co-morbidities such as cardiopulmonary complications or severe diabetes.

Resolution (cure) or improvement of type 2 diabetes mellitus 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 type 2 diabetes. 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 insulino-tropic 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.

Patients with BMI greater than or equal to 50 kg/m\(^2\) need a bariatric procedure to achieve greater weight loss. Thus, use of adjustable gastric banding, which results in less weight loss, should be most useful as one of the procedures used for patients with BMI less than 50 kg/m\(^2\). Malabsorptive procedures, although they produce more dramatic weight loss, they potentially result in nutritional complications, and the risks and benefits of these procedures must be carefully weighed in light of the treatment goals for each patient.

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.

Policy

Coding Information
Click the links below for attachments, coding tables & instructions.
Attachment I - CPT® code table & instructions
Attachment II - ICD code table

Policy Guidelines

General Criteria for Patient Selection and Coverage

Must meet one of the following Body Mass Index (BMI) criteria:

- BMI greater than 40 kg/m\(^2\); OR
- BMI 30kg/m\(^2\) - 34.9kg/m\(^2\) with co-morbidity of diabetes mellitus or metabolic syndrome and of Asian origin; OR
- BMI greater than 35 kg/m\(^2\) with at least one of the following co-morbidities:
• diabetes mellitus
• obstructive sleep apnea
• coronary artery disease
• hypertension
• medical arthropathy
• lower extremity lymphedema or venous obstruction

To calculate BMI, follow these instructions:
To convert pounds to kilograms, multiply pounds by 0.45
To convert inches to meters, multiply inches by 0.0254

In addition to the above general criteria, members must meet **ALL** of the following:

- The patient must be at least 18 years of age or have reached skeletal maturity.

- Participation in a medically supervised weight loss program within 12 months preceding surgery (may include commercial weight loss programs such as Weight Watchers, Jenny Craig, etc.). The medically supervised weight loss attempt(s) must include at least three (3) monthly medical visits under the direction of a medical doctor (MD or DO), physicians’ assistant (PA), nurse practitioner (NP) or a registered dietitian supervised by an MD, DO, PA, or NP. The patient’s participation in a structured weight loss regimen must be documented in the medical record by an attending practitioner who supervised the patient’s progress. A physician’s notation alone is not sufficient documentation. Documentation should include medical records indicating the patient’s adherence to the current nutrition and exercise program throughout the course of the medically supervised weight loss regimen. Such documentation is necessary to establish the patient’s ability to comply with the dietary and lifestyle changes necessary for maintaining weight loss following surgery.

- Preoperative evaluation by a licensed mental health provider (i.e. psychiatrist, licensed psychologist [PhD or MA] or licensed clinical social worker [LICSW]) to ensure the patient’s ability to understand, tolerate and comply with all phases of care and to ensure a commitment to long term follow-up requirements. The evaluation must document that any psychiatric, chemical dependency, or eating disorder contraindication to surgery have been ruled out. Documentation of this evaluation must be included in the request for prior authorization.

**NOTE:** Please note that psychological evaluation does not require psychological testing. The expectation is that the psychological/psychiatric clearance for bariatric surgery can in most instances be made on the basis of a diagnostic interview using DSM-(the most current version of the DSM) criteria alone and such evaluation does not necessarily require psychological or neuropsychological
testing. If psychological or neuropsychological testing is being requested in order to provide psychological/psychiatric clearance for gastric bypass surgery, please note it may be subject to additional prior authorization requirements.

- Completion of an appropriate medical work up, including but not limited to upper gastrointestinal series, endoscopy, preoperative laboratory studies and EKG. A complete physical examination by the attending surgeon and an assessment of thyroid levels is required. If co-morbid conditions (i.e. diabetes or cardiovascular disease) are present, an appropriate evaluation of those conditions is required to ensure the patient is capable of undergoing the procedure.

**Gastric Restrictive Procedures**

**When a service may be considered medically necessary**

Open gastric bypass using a Roux-en-Y anastomosis with an alimentary or “Roux” limb of 150 cm or less, or vertical-banded gastroplasty, may be considered medically necessary in the treatment of morbid obesity (see General Criteria for Patient Selection and Coverage) that has not responded to conservative measures.

Laparoscopic gastric bypass using a Roux-en-Y anastomosis may be considered medically necessary in the treatment of morbid obesity (see General Criteria for Patient Selection and Coverage) that has not responded to conservative measures.

Adjustable gastric banding, consisting of an adjustable external band placed around the stomach, may be considered medically necessary in the treatment of morbid obesity (see General Criteria for Patient Selection and Coverage) that has not responded to conservative measures.

Sleeve gastrectomy may be considered medically necessary in the treatment of morbid obesity (see General Criteria for Patient Selection and Coverage) that has not responded to conservative measures.

**When a service is considered investigational**

Gastric bypass using a Billroth II type of anastomosis, popularized as the mini-gastric bypass, is considered investigational as a treatment of morbid obesity.

Single anastomosis duodenoleal bypass with sleeve gastrectomy is considered investigational as a treatment of morbid obesity.

**Malabsorptive Procedures**

**When a service may be considered medically necessary**

Open or laparoscopic biliopancreatic bypass (i.e., the Scopinaro procedure) with duodenal switch may be considered medically necessary for treatment of morbidly obese patients with BMI of 50 kg/m² or greater that has not responded to
conservative measures.

**When a service is considered investigational**

Biliopancreatic bypass without duodenal switch is considered **investigational** as a treatment of morbid obesity.

Long-limb gastric bypass procedure (i.e., >150 cm) is considered **investigational** as a treatment of morbid obesity.

**Endoluminal (also called endosurgical, endoscopic or natural orifice) Procedures**

Endoscopic procedures (e.g., insertion of the StomaphyX™ device) 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, are considered **investigational**.

**Bariatric Surgery in Treatment of Type 2 Diabetes Mellitus**

Bariatric surgery is considered **investigational** as a cure for type 2 diabetes mellitus.

**Revision Bariatric Surgery**

**When a service may be considered medically necessary**

Revision surgery to address perioperative or late complications of a bariatric procedure is considered **medically necessary**. These include, but are not limited to, staple-line failure, obstruction, stricture, and non-absorption resulting in hypoglycemia or malnutrition, weight loss of 20% or more below ideal body weight.

Revision of a primary bariatric procedure that has failed due to dilation of the gastric pouch (documented by upper gastrointestinal examination or endoscopy) is considered **medically necessary** if the initial procedure was successful in inducing weight loss prior to pouch dilation and the patient has been compliant with a prescribed nutrition and exercise program and the patient still meets criteria (BMI) for bariatric surgery.

**Different surgical bariatric procedures**

**Gastric Restrictive Procedures**

**Vertical-Banded Gastroplasty (CPT® code 43842)**

Vertical-banded gastroplasty was formerly one of the most common gastric restrictive procedures performed in this country but has more recently declined in popularity. 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.
Adjustable Gastric Banding (CPT® code 43770—laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device [e.g., 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; currently, 1 such device is approved by the U.S. Food and Drug Administration (FDA) for marketing in the United States, Lap-Band (BioEnterics, Carpentier, CA). 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 co-morbid conditions, or those who are 100 lbs 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.”

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

“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 co-morbid 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.”

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 post-gastrectomy 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 (i.e., 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 to other
gastric restrictive procedures, including iron deficiency anemia, vitamin B-12 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 to the previous 100 cm. This change reflects the common practice in which the alimentary (i.e., 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.

**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.

**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 does not accurately describe the mini-gastric bypass, since CPT® code explicitly describes a Roux-en-Y gastroenterostomy, which is not used in the mini-gastric bypass.

**Sleeve Gastrectomy (CPT® code 43775—laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy [i.e., 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 can be done by the open or laparoscopic technique. Some surgeons have proposed this 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.

**Endoluminal (also called endosurgical, endoscopic or natural orifice) Procedures**

With these procedures access to the relevant anatomical 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 gastroplasty using a
transoral endoscopically guided stapler and placement of devices such as a duodenal-
jejunal sleeve and gastric balloon.

**Malabsorptive Procedures**

The multiple variants of malabsorptive procedures differ in the lengths of the
alimentary limb, the biliopancreatic limb, and the common limb, in which the
alimentary and biliopancreatic limbs are anastomosed. These procedures also may
include an element of a restrictive surgery based on the size of the stomach pouch.
The degree of malabsorption is related to the length of the alimentary and common
limbs. For example, a shorter alimentary limb (i.e., the greater the amount of
intestine that is excluded from the nutrient flow) will be associated with
malabsorption of a variety of nutrients, while a short common limb (i.e., the
biliopancreatic juices are allowed to mix with nutrients for only a short segment) will
primarily limit absorption of fat.

**Biliopancreatic Bypass (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:

1. A distal gastrectomy induces a temporary early satiety and/or the
dumping syndrome in the early postoperative period, both of which limit
food intake.
2. A 200-cm long “alimentary tract” consists of 200 cm of ileum connecting
the stomach to a common distal segment.
3. A 300- to 400-cm “biliary tract” connects the duodenum, jejunum, and
remaining ileum to the common distal segment.
4. 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, i.e., creating a selective malabsorption. The length of the
common segment will influence the degree of malabsorption.
5. 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.
Biliopancreatic Bypass with Duodenal Switch (CPT® code 43845—gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoleostomy [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 described here. 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, i.e., producing selective malabsorption by limiting the food digestion and absorption to a short common ileal segment.

Long-Limb Gastric Bypass (i.e., >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, i.e., 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.

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.

References
24214202
34. Miller K, Pump A, Hell E. Vertical banded gastroplasty versus adjustable gastric


64. Prachand VN, Davee RT, Alverdy JC. Duodenal switch provides superior weight loss in the super-obese (BMI > or =50 kg/m2) compared with gastric bypass. Ann Surg. Oct 2006;244(4):611-619. PMID 16998370

Lliner on obesity and type 2 diabetes: Systematic review and meta-analysis. Diabetes Obes Metab. Nov 5 2015. PMID 26537317
85. Morton JM. Weight gain after bariatric surgery as a result of large gastric stoma: endotherapy with sodium morrhuate to induce stomal stenosis may prevent the need for surgical revision. Gastrointest Endosc. Aug 2007;66(2):246-247. PMID 1764369


Blue Cross Blue Shield Association Technology Evaluation Center (TEC). Laparoscopic adjustable gastric banding in patients with body mass index less than 35 kg/m2 with weight-related comorbidity. TEC Assessments. 2012;Volume 27, Tab 3.


Related Policies
Gastric Electrical Stimulation
Sleep Disorders Diagnosis and Treatment

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer’s benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member’s contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required for services outlined in this policy. Benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered complete, see policy guidelines above.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required. NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member’s health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member’s benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member’s benefit.

Coverage varies according to the member’s group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract
language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member’s employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

**Policy Implementation/Update information**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>07/31/96</td>
<td>New policy</td>
</tr>
<tr>
<td>08/18/00</td>
<td>Policy updated to include expanded discussion of biliopancreatic bypass and gastric banding. Policy statement unchanged</td>
</tr>
<tr>
<td>05/31/01</td>
<td>Policy revised to include mini-gastric bypass</td>
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<tr>
<td>02/15/02</td>
<td>Policy revised to include further information on laparoscopic banding. Policy statement unchanged</td>
</tr>
<tr>
<td>07/17/03</td>
<td>Policy revised to include the conclusions of the 2003 TEC Assessment. Policy statement added stating laparoscopic gastric bypass is investigational</td>
</tr>
<tr>
<td>11/9/04</td>
<td>Policy revised to include revised CPT® code 43846; no other aspects of policy reviewed at this time. Coding updated in code table</td>
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<tr>
<td>12/14/05</td>
<td>Policy revised to include the results of the two 2005 TEC Assessments; policy statement regarding laparoscopic gastric bypass changed to medically necessary. Coding updated</td>
</tr>
<tr>
<td>07/20/06</td>
<td>Policy updated with sleeve gastrectomy. Sleeve gastrectomy is considered investigational</td>
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<tr>
<td>12/12/06</td>
<td>Policy updated with recent TEC Assessment; policy statement changed to indicate that adjustable gastric banding can be considered for those needing bariatric surgery. New references 18 (TEC Assessment) and 41 added. Information added to guidelines section that this policy does not apply to those under the age of 18.</td>
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<tr>
<td>02/14/08</td>
<td>Policy updated with literature review and clinical vetting. Policy statement added that endoscopic procedures for those who regain weight are investigational. Reference numbers 42 to 50 added</td>
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<tr>
<td>03/12/09</td>
<td>Policy update with literature review. Reference numbers 51-87 added. Policy statement added which states that this surgery is investigational as a cure for type 2 diabetes mellitus; statement added that biliopancreatic diversion with duodenal switch may be considered medically necessary; Policy Guidelines updated related to indications for surgery in adolescents and to further clarify definition of morbid obesity. Policy re-titled “Bariatric Surgery.”</td>
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<tr>
<td>05/14/09</td>
<td>Policy History for 3/12/09 corrected to say “Policy statement added which states that this surgery is investigational as a cure for type 2 diabetes mellitus”</td>
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<tr>
<td>06/2015</td>
<td>Medically supervised weight loss program requirement changed from 6 months to 3 months. CPT®- 43774 no longer requires PA.</td>
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Policy updated with literature review through December 9, 2015. References updated. Single anastomosis duodenoileal bypass with sleeve gastrectomy added as investigational. Added dx codes E66.2, K91.0-K91.3, K95.01, K95.09, K95.81, K95.89, E66.01, E66.09, E66.1, E66.3, E66.8 and E66.9.

Policy updated with verbiage clarifying that a psychological evaluation is needed, NOT psych testing, and additional PA may be needed. Moved summary of different surgical procedures to back of policy. Added medical arthropathy and LE lymphedema or venous as co-morbidities with BMI under 35. Clarified member must be of skeletal maturity. Changed weight loss program participation from 2 years to 12 months and clarified that a commercial weight loss program is acceptable. Added language and BMI criteria to address Asian population segment. Added related policy: Sleep Disorders Diagnosis and Treatment

Eligible Providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors          Date Approved

Gabrielle Bercy-Roberson, MD, MPH
Senior Medical Director
Chair, Health Policy Committee

Joshua Plavin, MD, MPH
Chief Medical Officer
### The following codes are considered medically necessary when applicable criteria have been met.

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Number</th>
<th>Description</th>
<th>Policy Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT®</td>
<td>43644</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)</td>
<td>Prior Approval Required</td>
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<tr>
<td>CPT®</td>
<td>43645</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption</td>
<td>Prior Approval Required</td>
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<td>CPT®</td>
<td>43770</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)</td>
<td>Prior Approval Required</td>
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<td>CPT®</td>
<td>43771</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only</td>
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<td>CPT®</td>
<td>43772</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only</td>
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<td>CPT®</td>
<td>43773</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only</td>
<td>Prior Approval Required</td>
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<td>CPT®</td>
<td>43774</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components</td>
<td>Prior Approval is Not Required</td>
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<td>CPT®</td>
<td>43775</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)</td>
<td>Prior Approval Required</td>
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<td>CPT®</td>
<td>Code</td>
<td>Description</td>
<td>Approval Required</td>
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<tr>
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<td>43842</td>
<td>Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty</td>
<td>Prior Approval Required</td>
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<tr>
<td></td>
<td>43843</td>
<td>Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty</td>
<td>Prior Approval Required</td>
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<tr>
<td></td>
<td>43845</td>
<td>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)</td>
<td>Prior Approval Required</td>
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<tr>
<td></td>
<td>43846</td>
<td>Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy</td>
<td>Prior Approval Required</td>
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<td>43847</td>
<td>Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption</td>
<td>Prior Approval Required</td>
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<td></td>
<td>43848</td>
<td>Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)</td>
<td>Prior Approval Required</td>
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<tr>
<td></td>
<td>43866</td>
<td>Gastric restrictive procedure, open; revision of subcutaneous port component only</td>
<td>Prior Approval Required</td>
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<td></td>
<td>43867</td>
<td>Gastric restrictive procedure, open; removal of subcutaneous port component only</td>
<td>Prior Approval Required</td>
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<td>43888</td>
<td>Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only</td>
<td>Prior Approval Required</td>
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<td></td>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
<td>Prior Approval is Not Required</td>
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<tr>
<td>HCPCS</td>
<td>S2083</td>
<td>Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline.</td>
<td>Prior Approval is Not Required</td>
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</table>
## ICD-10 Code Table

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>The following diagnoses are considered medically necessary when applicable criteria is met.</strong></td>
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<tr>
<td>E66.01</td>
<td>Morbid (severe) obesity due to excess calories</td>
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<tr>
<td>E66.09</td>
<td>Other obesity due to excess calories</td>
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<tr>
<td>E66.1</td>
<td>Drug-induced obesity</td>
</tr>
<tr>
<td>E66.2</td>
<td>Morbid (severe) obesity with alveolar hypoventilation</td>
</tr>
<tr>
<td>E66.3</td>
<td>Overweight</td>
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<tr>
<td>E66.8</td>
<td>Other obesity</td>
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<tr>
<td>E66.9</td>
<td>Obesity, unspecified</td>
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<tr>
<td>K91.0</td>
<td>Vomiting following gastrointestinal surgery</td>
</tr>
<tr>
<td>K91.1</td>
<td>Postgastric surgery syndromes</td>
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<tr>
<td>K91.2</td>
<td>Postsurgical malabsorption, not elsewhere classified</td>
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<tr>
<td>K91.3</td>
<td>Post procedural intestinal obstruction</td>
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<tr>
<td>K95.01</td>
<td>Infection due to gastric band procedure</td>
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<tr>
<td>K95.09</td>
<td>Other complications of gastric band procedure</td>
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<tr>
<td>K95.81</td>
<td>Infection due to other bariatric procedure</td>
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<tr>
<td>K95.89</td>
<td>Other complications of other bariatric procedure</td>
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</tbody>
</table>