

Corporate Medical Policy

Bariatric Surgery

Description of Procedure or Service

A variety of surgical procedures are performed with intention to aid in weight loss for morbid obesity. Procedures include those that restrict stomach volume and/or cause malabsorption of nutrients. Weight loss occurs by the decreased size or malabsorption or by the combination of both gastric restriction and malabsorption. The goal is to cause significant weight loss and thereby avoid or reduce the development of obesity-related comorbidities.

Background

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, hypertension, or obstructive sleep apnea. The evidence for bariatric surgery procedures in individuals who have diabetes without morbid obesity includes RCTs, nonrandomized comparative studies, and case series. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Other carriers report a high rate of remission of diabetes in patients undergoing gastric bypass surgery. A number of small RCTs have reported that remission of diabetes is higher in patients treated with bariatric surgery and that remission is maintained in a large percentage of patients up to 5 years' post-surgery. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

Revision Bariatric Surgery is defined as the surgical adjustment or alteration of a prior bariatric procedure. Generally, such intervention may be warranted for proven complications of the original weight loss surgery, such as stricture, obstruction, pouch dilatation, erosion, or band slippage when the complication causes abdominal pain, inability to eat or drink, or causes unmanageable vomiting of prescribed meals. Revisions are sometimes desired by a member or provider when an original procedure has not led to the desired impact. In such cases, while surgical revision might be considered feasible, it does not necessarily mean that such a service would be considered medically necessary: in many cases the procedure was appropriately performed and remains functional, but other factors have adversely impacted the response to surgery, such as poor compliance with dietary and exercise recommendations, inadequate surgical follow-up, etc.

Open or Laparoscopic gastric bypass using a Roux-en-Y anastomosis

Roux-en-Y gastric bypass, the typical form of gastric bypass, causes weight loss through both restricting stomach size and malabsorption. There is good evidence that patients see significant weight loss following RYGB, although weight loss below the obesity threshold is not typical. There is weak evidence for weight loss lasting for as long as 10 years. Complications are frequent with RYGB but treatable. Some do experience serious complications, death or limited weight loss. Laparoscopic may be chosen to minimize surgical complications and recovery time.

Laparoscopic adjustable gastric banding (LASGB)

The LASGB causes weight loss by restriction only. LASGB is considered a simpler and reversible procedure with fewer deadly complications but with a higher rate of complications occurring later in recovery, many of which require an additional operation. LASGB require band adjustments and need sometimes frequent post procedure visits with professional staff experienced in bad adjustments.

Open or laparoscopic biliopancreatic bypass (i.e., the Scopinaro procedure) with duodenal switch

Biliopancreatic bypass or diversion (BPD)/(BPD-DS) uses both restriction and malabsorption to induce weight loss. Limited to moderate evidence is available for BPD and BPD-DS. The evidence available shows significant and long-term weight loss from this procedure. Evidence is weak in determining short and long term impact on comorbidities, overall survival, and side effects.

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.

Gastric Bypass with Long Limb

Another carrier reviewed studies that compared outcomes of standard or "short-" limb gastric bypass with outcomes of "long-" limb gastric bypass. There were 6 comparative studies, 2 or more in which different lengths of the Roux limb were compared. However, although the categorization of patients into "standard" versus "long-limb" is based on the length of the Roux (alimentary) limb, there is not a definite cutoff for long- versus standard limbs. In these studies, there was variability in the lengths of the Roux limbs for both the standard gastric bypass and for the long-limb groups. Most comparisons of weight loss do not reveal significant differences between short- and long-limb gastric bypass. The strongest evidence in this category is from 2 RCTs .

Vertical Banded Gastroplasty (VBG):

VBG has fallen into disfavor because of inadequate long-term weight loss.. VBG is one of the early types of bariatric surgery developed in the 1980s. This is a purely restrictive procedure that has been largely replaced by laparoscopic adjustable gastric banding (LAGB) or sleeve gastrectomy (SG). Weight loss with VBG is substantial, but there is a high rate of revisions and reoperations due to staple line disruption, perforation, band erosion or disruption, and stenosis at the band site.

Gastroplasty (Stomach Stapling)

Overall, clinical studies have shown that about 40 % of persons who have this operation do not achieve loss of more than half of their excess body weight. In the long-term, 5 or more years after surgery, only about 30 % of patients have maintained a successful weight loss. Studies have reported that many patients must undergo another revisional operation to obtain the results they seek.

Loop Gastric Bypass

Although patients can have increased frequency of bowel movements, increased fat in their stools, and impaired absorption of vitamins, recent studies have reported good results. The loop gastric bypass developed years ago has generally been abandoned by most bariatric surgeons as unsafe. Although easier to perform than the RYGB, it has been shown to create a severe hazard in the event of any leakage after surgery, and seriously increases the risk of ulcer formation, and irritation of the stomach pouch by bile

Mini Gastric Bypass

The "mini gastric bypass" has been promoted as a new surgical treatment for severe obesity. It involves laparoscopic construction of a large and elongated gastric pouch and a loop gastric bypass with distal diversion) to reduce food absorption. This is a major surgical procedure. The evidence for the mini gastric bypass has come from a single investigator, thus raising questions about the generalization and validity of the reported findings. The mini-gastric bypass has not been subjected to a prospective clinical outcome study in peer-reviewed publication.

Silastic Ring Vertical Gastric Bypass (Fobi Pouch)

The Fobi pouch, developed by California surgeon Mathias A.L. Fobi, is a modification of gastric bypass surgery. The modifications to gastric bypass surgery are designed to prevent post-surgical enlargement of the gastric pouch and stoma, there is a paucity of direct comparative studies of the Fobi pouch to traditional gastric bypass surgery. All of the published literature has been limited to descriptive articles, case series, and a prospective non-randomized controlled study. These studies were from a single group of investigators, raising questions about the generalization of the findings.

Intragastric Balloon (Silicone Intragastric Balloon)

Intragastric balloon is intended to reduce gastric capacity, causing satiety, making it easier for patients to take smaller amounts of food. Randomized, controlled clinical studies, however, have found no

increase in weight loss with the intragastric balloon plus dieting versus dieting alone (Rigaud et al, 1995; Geliebter et al, 1991; Mathus-Vliegen et al, 1990; Lindor et al, 1987).

Reshape Balloon

There is a lack of data on the durability of the results with the ReShape Integrated Dual Balloon System. It is unclear what benefit there is from a temporary reduction in weight. Furthermore, an Up-to-date review on " Bariatric surgical operations for the management of severe obesity: Descriptions " lists intragastric balloon as an investigational procedure. It states that "As much as 33 % excess weight loss has been reported in trials conducted outside of the United States with devices not approved by the FDA. After 5 years of surveillance, however, only 23 % of patients maintained more than 20 % of their excess weight loss"

Stomaphyx

This is an endoluminal fastener and delivery system used to tighten esophageal tissue. There is only limited evidence on the effectiveness of the StomaphyX in bariatric surgery repair/revision. In a prospective, single-center, randomized, single-blinded study examined the safety and effectiveness of endoscopic gastric plication with the StomaphyX device versus a sham procedure for revisional surgery in RYGB (performed at least 2 years earlier) patients to reduce regained weight. The authors concluded that StomaphyX treatment failed to achieve the primary efficacy target and resulted in early termination of the study.

Laparoscopic Gastric Plication

Brethauer presented the results of a feasibility study using laparoscopic gastric plication for weight loss achieved without stapling or banding.

Sclerotherapy for Dilated Gastrojejunostomy

Surgeons have tried endoscopic injection of sclerosing agents to create scar and a smaller anastomosis, with variable effects." For patients with have inadequate weight loss or significant weight regain and who have a dilated gastrojejunostomy after Roux-en-Y gastric bypass (RYGB) who. It is thought that these patients lose restriction because of the dilated gastrojejunostomy and thus overeat. In the textbook Townsend: Sabiston Textbook of Surgery (2012) this is considered an investigational bariatric procedure.

Gastrointestinal Liners: (EndoBarrier, Valen TX)

Endoscopic duodenal-jejeunal bypass is the endoscopic placement of a duodenal-jejeunal bypass sleeve (DIBL) which lines the first section of the small intestine causing food to be absorbed further along the intestine. Once implanted, the device is purported to influence gastrointestinal hormones and satiety. While these procedures look promising in several studies, they suffer from small size, short follow up duration, and lack of blinding. Most authors have called for larger studies with long term follow before wide acceptance

The pre-operative surgical preparatory regimen should include cessation counseling for smokers. The National Institutes of Health Consensus Statement (1998) states that all smokers should be encouraged to quit, regardless of weight. Smoking cessation is especially important in obese persons, as obesity places them at increased risk for cardiovascular disease. Severely obese persons are at increased risk of surgical complications.

The surgical center where surgery is to be performed should be accomplished in bariatric surgery with a demonstrated commitment to provide adequate facilities and equipment. A number of studies have demonstrated a relationship between surgical volumes and outcomes of obesity surgery. Most recently, an assessment by the Canadian Agency for Drugs and Technologies in Health (CADTH) stated that their volume-outcome review found that higher surgical volumes were associated with better clinical outcomes. CADTH was not, however, able to identify specific thresholds for surgical volume that were associated with better clinical outcomes.

A Multidisciplinary Care Task Group conducted a systematic review of the literature to provide evidence-based guidelines for patient selection and to recommend the medical and nutritional aspects of multidisciplinary care required to minimize peri-operative and post-operative risks in patients with severe obesity who undergo weight loss surgery. The Task Group recommended multi-disciplinary screening of weight loss surgery patients to ensure appropriate selection; pre-operative assessment for cardiovascular, pulmonary, gastrointestinal, endocrine, and other obesity-related diseases associated with increased risk for complications or mortality; pre-operative weight loss and cessation of smoking; peri-operative prophylaxis for deep vein thrombosis and pulmonary embolism (PE); pre-operative and post-operative education and counseling by a registered dietitian; and a well-defined post-surgical diet progression

Anderin et al found that weight loss before bariatric surgery is associated with marked reduction of risk of postoperative complications. The investigators reported that the degree of risk reduction seems to be related to amount of weight lost and patients in the higher range of BMI are likely to benefit most from pre-operative weight reduction

Candidates for obesity surgery should begin a weight reduction diet prior to surgery. The purpose of a pre-operative nutrition program prior to obesity surgery are to test patient motivation, to reduce perioperative morbidity, to accustom patients to the restriction of food intake after surgery, and to increase total weight loss (van de Weijgert et al,1999; Jung and Cusciheri, 2000; Pekkarinen et al, 1997; Martin et al, 1995). Even super obese patients (BMI greater than 50) may benefit from initiating a nutrition and exercise program prior to surgery. For maximal benefit, dieting should occur proximal to the time of surgery, and not in the remote past to reduce surgical risks and improve outcomes.

Contraindications to Obesity Surgery:

A Multidisciplinary Care Task Group (Saltzman et al, 2005) identified contraindications to weight loss surgery, including unstable or severe coronary artery disease, severe pulmonary disease, portal hypertension with gastric or intestinal varices, and/or other conditions thought to seriously compromise anesthesia or wound healing. The Task Group also noted that weight loss surgery is contraindicated in those who are unable to comprehend basic principles of weight loss surgery or follow operative

instructions. The Task Group stated that any combination of the following factors -- revision surgery, male, greater than 50 years of age, BMI greater than 50 kg/m², and obstructive sleep apnea, hypertension, and type 2 diabetes -- indicates high risk.

Requirement that Obesity be Persistent:

Obesity surgery is not indicated for persons with transient increases in weight (Collazo-Clavell, 1999). Guidelines of the American Association of Clinical Endocrinologists and the American College of Endocrinology (1998) and guidelines on obesity surgery from the Massachusetts Department of Health and Human Services (2006) state that surgery candidates should be severely obese for a period of time.

Obesity Surgery in Children and Adolescents: According to available guidelines, obesity surgery is generally indicated for persons age 18 and older (AACE, 1998). Children and adolescents are rapidly growing, and are therefore especially susceptible to adverse long-term consequences of nutritional deficiencies from the reduced nutrient intake and malabsorption that is induced by obesity surgery. It is not known whether the benefits of obesity surgery in children and adolescents outweigh the increased risks.

According to a panel of experts (Inge et al) bariatric surgery may be an appropriate treatment for severe obesity in adolescents who have completed bone growth. According to the recommendations by the expert panel, potential candidates for bariatric surgery should be referred to centers with multi-disciplinary weight management teams that have expertise in meeting the unique needs of overweight adolescents. Consideration for bariatric surgery is generally warranted only when adolescents have experienced failure of 6 months of organized weight loss attempts and have met certain criteria: severe obesity (a BMI of 40) and severe co-morbidities, or super obesity (BMI of 50) and less severe co-morbidities that may be remedied with weight loss; and have attained a majority of skeletal maturity (generally 13 years of age for girls and 15 years of age for boys). Surgery should only be performed at facilities that are equipped to collect long-term data on clinical outcomes. The panel recommended the Roux-en-Y gastric bypass method of surgery over the simpler, newer technique of implanting an adjustable gastric band since gastric bands are less effective and younger patients would probably need replacement as they age.

Regulatory Status

Bariatric weight loss surgeries are surgical procedures and, as such, are not regulated by the FDA.

However, the FDA does regulate manufacturing practices, distribution and use of devices for such procedures.

Policy Statement

GEHA will provide coverage for bariatric weight loss surgery when it is determined to be medically necessary because the medical criteria and guidelines as documented below have been demonstrated

and criteria within the GEHA member brochure benefit description has been met. 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.

Repair of a hiatal hernia that is diagnosed preoperatively or at the time of bariatric surgery in members who have not demonstrated signs and/or symptoms for repair, is considered incidental and not separately payable.

Guidance in this policy relates specifically to the determination of medical necessity. Please note that payment for specific services will always be dependent upon additional factors including, correct coding, contractual requirements, GEHA payment policy, etc. The fact that a service is determined to be clinically necessary does not dictate payment processes.

Benefit Application

This medical policy relates only to the services or supplies described herein. Please refer to the member's benefit booklet for availability of benefits. Benefit eligibility may be limited by specific criteria designated in the member's benefit booklet.

When bariatric weight loss surgery is covered:

To be eligible for coverage of any primary bariatric procedure, the individual must show documentation of:

- A. Psychological clearance of the member's ability to understand and adhere to pre- and post-operative program based on a psychological assessment performed by a licensed professional mental health practitioner; and
- B. Documentation that the member has not smoked in the six months prior to surgery; and
- C. Member has not been treated for substance use for one year prior to surgery and there is no evidence of substance use during the one-year period prior to surgery; and
- D. Failure to lower the body mass index within the last 12 months through a medically supervised program of at least 6 months duration that includes dietician consultation, low calorie diet, increased physical activity, behavioral modification and demonstration of clinically significant obesity as defined below.
 - I. For adults aged 18 years or older, presence of persistent severe obesity, documented in concurrent clinical records, defined as any of the following:
 - A. Initial Body mass index (BMI) (see appendix) exceeding 40; or
 - B. Initial BMI greater than 35 in conjunction with any of the following severe co-morbidities:
 - i. Clinically significant obstructive sleep apnea; or
 - ii. Coronary heart disease, with objective documentation (by exercise stress test, radionuclide stress test, pharmacologic stress test, stress

- echocardiography, CT angiography, coronary angiography, heart failure or prior myocardial infarction); or
 - iii. Refractory Hyperlipidemia defined as unachievable acceptable levels of lipids despite maximal diet and pharmacological therapy; or
 - iv. Obesity Induced Cardiomyopathy ; or
 - v. Severe Arthropathy of the spine or weight bearing joints where joint replacement has been recommended but obesity prohibits appropriate surgical management; or
 - vi. Medically Refractory hypertension defined as blood pressure > 140 mmHG systolic and/or 90 mmHg diastolic despite medical treatment with maximal dose of three antihypertensive medications; or
 - vii. Type II Diabetes Mellitus as diagnosed by the American Diabetes Association Diagnostic criteria of A1C greater than 6.5%, or fasting blood glucose of 126 mg/dl or greater, or oral glucose tolerance test of 200 mg/dl or greater or random (casual) plasma glucose test of 200 mg/dl.
- II. For adolescents who have documented completed bone growth and the presence of obesity with severe co-morbidities:
- A. Preoperative preparatory program BMI exceeding 40 with one or more of the following serious co-morbidities:
 - i. Clinically significant obstructive sleep apnea; or
 - ii. Type 2 diabetes mellitus (defined above); or
 - iii. Pseudo tumor comorbidities; or
 - iv. Hypertension.
 - B. Preoperative preparatory program BMI exceeding 50 with one or more of the following less serious co-morbidities:
 - i. Medically refractory hypertension (defined above); or
 - ii. Dyslipidemias; or
 - iii. Nonalcoholic steatohepatitis; or
 - iv. Venous stasis disease; or
 - v. Significant impairment in activities of daily living; or
 - vi. Intertriginous soft-tissue infections; or
 - vii. Stress urinary incontinence; or
 - viii. Gastroesophageal reflux disease; or
 - ix. Weight-related arthropathies that impair physical activity.

When bariatric weight loss surgery revision is covered:

GEHA considers revision bariatric surgery eligible for coverage when one of the following medical necessity criteria have been demonstrated:

- a. Revision surgery to address perioperative or late complications of the original bariatric procedure. These include, but are not limited to, staple-line failure, obstruction, stricture,

erosion, non-absorption resulting in hypoglycemia or malnutrition, weight loss of 20% or more below ideal body weight, band herniation, and band slippage that cannot be corrected with manipulation or adjustments.

b. Revision of a primary bariatric procedure that has failed due to dilation of the gastric pouch or dilation proximal to an adjustable gastric band or other restrictive procedure (documented by upper gastrointestinal examination or endoscopy), but only when the initial procedure was successful in inducing weight loss prior to dilation and the patient has objectively demonstrated compliance with a prescribed nutrition and exercise program.

c. Repeat surgical procedures for revision or conversion to another surgical procedure (that is also considered medically necessary within this document) for inadequate weight loss, (that is, unrelated to a surgical complication of a prior procedure) when all the following criteria are met:

i. The individual continues to meet all the medical necessity criteria for bariatric surgery, including current pre-operative nutritional assessment; and

ii. There is objective documentation of compliance with the previously prescribed postoperative dietary and exercise program (this must include medical records demonstrating compliance with recommended post-surgical protocols); and

iii. The maximum weight loss following the original surgery was less than 50% of pre-operative excess body weight and current weight remains at least 30% over ideal body weight (taken from standard tables for adult weight ranges based on height, body frame, gender and age).

Bariatric weight loss surgery is not covered when:

1. The above criteria is not met, or
2. The treatment regime and/or procedure is considered experimental or investigational, or
3. The treatment regime and/or procedure is listed as a non-covered service per this policy.

GEHA considers the following bariatric weight loss surgeries experimental and investigational and therefore not covered. This includes, but is not limited to, the following:

1. Bariatric surgery as a treatment for idiopathic intracranial hypertension
2. Bariatric surgery for diabetes in patients with a body mass index less than 35 kg/m²
3. Gastric bypass as a treatment for gastroparesis
4. Vertical-banded gastroplasty, also known as stomach stapling
5. Gastric bypass using a Billroth II type of anastomosis (mini-gastric bypass)
6. Biliopancreatic bypass without duodenal switch
7. Long-limb gastric bypass procedure (i.e., >150 cm)
8. Two-stage bariatric surgery procedures (e.g., sleeve gastrectomy as initial procedure followed by biliopancreatic diversion at a later time)

9. Endoscopic procedures (including but not limited to insertion of the StomaphyX™ device, insertion of a gastric balloon, endoscopic gastroplasty, or use of an endoscopically placed duodenal-jejunal sleeve) as a primary bariatric procedure or as a revision procedure to treat weight gain after bariatric surgery to remedy large gastric stoma or large gastric pouches.
10. Laparoscopic gastric plication
11. Single anastomosis duodenal ileal bypass with sleeve gastrectomy
12. Natural orifice transoral endoscopic surgery (NOTES) techniques for bariatric surgery including:
 - i. Gastrointestinal liners (endoscopic duodenal-jejunal bypass, endoscopic gastrointestinal bypass devices; e.g., EndoBarrier and the ValenTx Endo Bypass System); or
 - ii. Intra-gastric balloon ReShape Integrated Dual Balloon System); or
 - iii. Restorative obesity surgery, endoluminal (ROSE) procedure for the treatment of weight regain after gastric bypass surgery; or
 - iv. Transoral gastroplasty (TG) (vertical sutured gastroplasty; endoluminal vertical gastroplasty; endoscopic sleeve gastroplasty); or
 - v. Use of any endoscopic closure device (Over the Scope clip [OTSC] system set, Apollo OverStitch endoscopic suturing system, StomaphyX endoluminal fastener and delivery system) in conjunction with NOTES;
13. Open adjustable gastric banding
14. Roux-en-Y gastric bypass as a treatment for gastroesophageal reflux in non-obese persons
15. Sclerotherapy for the treatment of dilated gastrojejunalostomy following bariatric surgery
16. Silastic ring vertical gastric bypass (Fobi pouch)
17. Vagus nerve blocking (e.g., the VBLOC device, also known as the Maestro Implant or the Maestro Rechargeable System)

Policy Guidelines

The GEHA coverage policy pertaining to consideration of bariatric surgery is based on the NIH Consensus Conference on Surgical Treatment of Morbid Obesity (1998) which state that obesity surgery should be reserved only for patients who have first attempted medical therapy: “Weight loss surgery should be reserved for patients in whom efforts at medical therapy have failed and who are suffering from the complications of extreme obesity.” Surgery for severe obesity is usually considered an intervention of last resort with patients having attempted other forms of medical management (such as behavior change, increased physical activity and drug therapy) but without achieving permanent weight loss (Colquitt et al, 2002; NIH, 1995). Surgery is indicated for persons with severe obesity (BMI of 40 kg/m² or more) or for persons with a BMI of 35 kg/m² or more and serious co-morbidities such as diabetes, coronary heart disease, or obstructive sleep apnea. Ideally patients selected for surgery should have no major perioperative risk factors, a stable personality, no eating disorders, and have lost some weight prior to surgery. The patient's ability to lose weight prior to surgery makes surgical intervention easier

and also provides an indication of the likelihood of compliance with the severe dietary restriction imposed on patients following surgery.

The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) has issued evidence-based guidelines for the management of hiatal hernias. The authors note that the general methodologic quality of available studies is low. 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.

- All symptomatic paraesophageal hiatal hernias should be repaired (high quality evidence, strong recommendation), particularly those with acute obstructive symptoms or which have undergone volvulus
- The SAGES recommendation is for repair of all hiatal hernias when present at the time of bariatric surgery (weak evidence and rating).

Physician Documentation

Provide the following documentation with your request for members age 18 and older:

- Current history and physical including BMI;
- Clinical records documenting progress during a physician supervised weight, dietary and exercise regimen for the immediate previous 6 to 12 months prior to your request for authorization. Note – the documentation must reflect that the physician was participative in this process;

For members with a preoperative preparatory program BMI between 35 and 39 include clinical records documenting one or more of the comorbidities identified within this policy and the corresponding treatment. For members less than 18 years of age, you will need to provide the above in addition to:

- Documentation of completed bone growth
- For members less than 18 years of age with a preoperative preparatory program BMI exceeding 40 or 50, include clinical records documenting one or more of the comorbidities identified per BMI within this policy and the corresponding treatment.

Provide the following documentation with your request for a weight-loss revision surgery:

- All of the above requested documents as applicable per the age and BMI group; and
- Clinical records documenting the indications for revision listed within this policy.

CPT or HCPCS codes covered if criteria are met:

- 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)
- 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 (i.e., 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
- 43855 Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; with vagotomy
- S2083 Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline

CPT or HCPCS not covered for indications listed in this coverage policy:

- 15876 Suction assisted lipectomy; head and neck
- 15787 Suction assisted lipectomy; trunk
- 15878 Suction assisted lipectomy; upper extremity

- 15879 Suction assisted lipectomy; lower extremity
- 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
- 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)
- 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
- 43848 Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
- 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
- 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
- 47000 Biopsy of liver, needle; percutaneous (In the absence of signs or symptoms of liver disease such as elevated liver enzymes or enlarged liver)

47001 Biopsy of liver, needle; when done for indicated purpose at time of other major procedure (In the absence of signs or symptoms of liver disease such as elevated liver enzymes or enlarged liver), (List separately in addition to code for primary procedure)

47100 Biopsy of liver, wedge, (In the absence of signs or symptoms of liver disease such as elevated liver enzymes or enlarged liver)

Other CPT codes related to this coverage policy when billed or requested with a bariatric surgery:

43280 Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)

43281 Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh

43659 Unlisted laparoscopy procedure, stomach

43830 Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure)

43840 Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury

43999 Unlisted procedure, stomach

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Policy implementation and updates

12/2017	Revised coverage criteria and updated.
06/2018	Technical correction and reformatting: Preauthorization Requirements
12/2018	Clarification of physician documentation needs. Added clarification with the benefit application language.

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