Medical Policy:
Bariatric Surgery(Commercial)

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
MG.MM.SU.18ov2	**01/01/2020**	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

 The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

Definitions

Bariatric surgical procedure types	Restrictive, malabsorptive and combined, all of which may be performed using either the laparoscopic or open approach. 1. Restrictive — the basic philosophy of restrictive procedures is to create a small gastric reservoir that forces the patient to eat less at any one time. This objective is achieved by reducing the size of the stomach pouch to 30 mL or less and leaving only a small channel to the remaining stomach. 2. Malabsorptive — the goal of purely malabsorptive procedures is to bypass a major portion of the absorptive surface of the small intestine for the achievement of rapid, sustained weight loss without a necessary change in eating habits. Purely malabsorptive procedures (without a restrictive component) are not recommended because of the potential for complications,

<table>
<tr><td></td><td>including liver failure and electrolyte depletion.

3. Combined restrictive and malabsorptive (hybrid techniques) — the basic philosophy of combined restrictive and malabsorptive procedures is to balance the benefits and risks of the two approaches.</td></tr>
<tr><td>Body Mass Index (BMI)</td><td>A quantitative method of defining obesity in a ratio of weight to height (kg/m²).</td></tr>
<tr><td>Classification</td><td><table><tr><th>Class</th><th>BMI</th></tr><tr><td>Overweight</td><td>25–29.9 kg/m²</td></tr><tr><td>Obese (class I)</td><td>30–34.9 kg/m²</td></tr><tr><td>Severe obesity (class II)</td><td>35–39.9 kg/m²</td></tr><tr><td>Clinically severe (also referred to as extreme or morbid) obesity (class III)</td><td>40–49.9 kg/m²</td></tr><tr><td>Super obesity</td><td>50–59.9 kg/m²</td></tr><tr><td>Super-super obesity</td><td>60+ kg/m²</td></tr></table></td></tr>
<tr><td>Biliopancreatic Diversion with duodenal switch (BPD/DS)</td><td>A combined malabsorptive / restrictive procedure whereby a suprapapillary Roux-en-Y duodeno-jejunostomy is performed in combination with a 70%–80% greater curvature gastrectomy (sleeve resection of the stomach; continuity of the gastric lesser curve is maintained while simultaneously reducing stomach volume). A long-limb Roux-en-Y is then created. The efferent limb acts to decrease overall caloric absorption and the long biliopancreatic limb, diverting bile from the alimentary contents, is intended specifically to induce fat malabsorption.</td></tr>
<tr><td>Laparoscopic adjustable gastric banding (LAGB)</td><td>A gastric-restrictive implant device used as an alternative to a gastric-restrictive surgery procedure to treat morbid obesity. The system consists of a band of silicone elastomer with an inflatable inner shell and a buckle closure connected by tubing to an access port placed outside the abdominal cavity. The inner diameter of the band can be readily adjusted by the addition or removal of saline through the access port. The band is placed laparoscopically around the upper stomach, 1 cm below the esophagogastric junction. (Must be FDA-approved for Plan consideration)</td></tr>
<tr><td>Roux-en-Y gastric bypass (RYGB)</td><td>A large portion (approximately 90%) of the stomach is excluded. A gastric pouch is created and anastomosed to the proximal jejunum, causing weight reduction due to a reduction of food intake and mild malabsorption.</td></tr>
<tr><td>Sleeve gastrectomy</td><td>A new procedure that is becoming increasingly popular. In this operation, a tubular stomach is created along the lesser curvature by excising the greater curvature. Approximately an 80–90% gastrectomy is performed. This is a restrictive procedure and absorption remains normal.</td></tr>
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<tr><td>Vertical gastric banding (VGB) / vertical-banded gastroplasty (VBG) (vertical gastric stapling or partitioning)</td><td>A vertical row of staples and a horizontally placed reinforcing band are positioned across the stomach, creating a proximal pouch and narrowed food outlet. Patients become full post ingestion of only small food amounts.</td></tr>
<tr><td>The Obesity Surgery Mortality Risk Score (OS-MRS)</td><td>A risk stratification tool that physicians should utilize when determining candidacy of the BMI ≥ 50 kg/m2 member. The OS-MRS assigns 1 point to each of 5 preoperative variables: Age, hypertension, male gender, known risk factors for pulmonary embolism (i.e., previous thromboembolism, preoperative vena cava filter, hypoventilation, pulmonary hypertension) and BMI.

<table>
<tr><th colspan="2">Obesity Surgery Mortality Risk Score</th></tr>
<tr><th>Risk factor</th><th>Points</th></tr>
<tr><td>Age > 45 years</td><td>1</td></tr>
<tr><td>Hypertension</td><td>1</td></tr>
<tr><td>Male sex</td><td>1</td></tr>
<tr><td>Risk factors for pulmonary embolism</td><td>1</td></tr>
<tr><td>Body mass index ≥ 50 kg per m2</td><td>1</td></tr>
<tr><td></td><td>Total:</td></tr>
<tr><td>Risk group (score)</td><td>Postoperative mortality risk (deaths/total number of patients who underwent bariatric surgery)</td></tr>
<tr><td>Low (0 or 1 points)</td><td>5/2164 (0.2%)</td></tr>
<tr><td>Moderate (2 or 3 points)</td><td>25/2142 (1.2%)</td></tr>
<tr><td>High (4 or 5 points)</td><td>3/125 (2.4%)</td></tr>
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Guideline

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

1. Age ≥ 18.[1]
2. Full growth achieved.
3. Absence of specific obesity etiology (i.e., endocrine disorders, e.g., adrenal or thyroid conditions, or treatment of metabolic cause provided, as applicable).
4. Psychological clearance by a mental health professional.

   If the member has received any behavioral health issue intervention (i.e., counseling or drug therapy) within the past 12 months, then the mental health provider should indicate that the issue of surgery has been discussed with the member and that there are no identified contraindications to the proposed surgery.

   In addition, the member should have no history of substance abuse, or if there is a

positive history, the documentation should indicate that the member has been substance abuse free for

> 1 year or that he/she is in a controlled treatment program and is stabilized.

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

AND

5. BMI ≥ 40 kg/m² without comorbidities **or** BMI 35–39.9 kg/m² with ≥ 1 significant comorbidity.

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

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

Gastric Band Adjustments

Appropriate as follows:

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

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

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

Adjustments would be expected at approximately 6-week intervals until appropriate fill volume has been achieved (member is experiencing early and prolonged satiety with small meal sizes, satisfactory weight loss).
Adjustments should be performed in the outpatient setting and without fluoroscopic guidance unless the port is not palpable, there is difficulty accessing the port, or leakage is suspected.

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1. Surgical requests for members < 18 years may be reviewed on a case-by-case basis and should only be performed in centers where there is a multidisciplinary approach to pediatric obesity and only in rare circumstances (e.g., Prader-Willi syndrome).

2. The member must be unable to participate in employment and/or normal activities as a result of the clinically severe obese condition, which could be resolved by weight reduction (e.g., treatable joint disease).

Surgical Revision

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

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

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

Surgical Repetition

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

1. Insufficient weight loss (success defined as a weight loss of > 50% of excess body weight) within 2 years post primary procedure.

2. The medically necessary criteria (as outlined above) are met.

Note: Member compliance with prescribed postprocedure nutrition and exercise program is prerequisite to consideration.

Postsurgical Panniculectomy Requests
(See Cosmetic Surgery Procedures and/or Abdominoplasty/Panniculectomy)

Limitation/Exclusion

1. Surgical revision is not considered medically necessary for members who have a functional operation (without any evidence of medical abnormality) because of inadequate weight loss.
2. Repair of an asymptomatic or incidentally identified hiatal hernia (CPT codes 43280, 43281, 43282, 43289, 43499 or 43659) will be denied as incidental/inclusive procedures when reported with bariatric surgery code ranges 43770–43775 and 43842–43848, 43644, 43645, 43886, 43887 or 43888). Modifier 59 will not override these codes as hiatal hernia repair is considered an integral part of obesity surgery.
3. All other gastric bypass/restrictive procedures (and other treatment modalities not listed above as medically necessary) are considered investigational due to insufficient evidence of therapeutic value. These include, but are not limited to, minimally invasive endoluminal gastric restrictive surgical techniques (e.g., EndoGastric StomaphyX™ endoluminal fastener and delivery system); laparoscopic gastric plication/laparoscopic greater curvature plication (LGCP), with or without gastric banding; balloon-type systems (e.g., ReShape® Integrated Dual Balloon System) and vagus nerve-blocking devices (e.g., MAESTRO® Rechargeable System).

Coding Criteria

To access the codes, please download the policy and click on the links below.

	Applicable CPT and Diagnosis Codes

References

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Specialty matched clinical peer review.

Revision history

DATE	REVISION
01/01/2020	Retired MCG criteria for this service ConnectiCare has adopted the clinical criteria of its parent corporation, EmblemHealth