Clinical Policy: Bariatric Surgery

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Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

There are two categories of bariatric surgery: restrictive procedures and malabsorptive procedures. Gastric restrictive procedures include procedures where a small pouch is created in the stomach to restrict the amount of food that can be eaten, resulting in weight loss. The laparoscopic adjustable gastric banding (LAGB) and laparoscopic sleeve gastrectomy (LSG) are examples of restrictive procedures. Malabsorptive procedures bypass portions of the stomach and intestines causing incomplete digestion and absorption of food. Duodenal switch is an example of a malabsorptive procedure. Roux-en-y gastric bypass (RYGB), biliopancreatic diversion with duodenal switch (BPD-DS), and biliopancreatic diversion with gastric reduction duodenal switch (BPD-GRDS) are examples of restrictive and malabsorptive procedures.

Policy/Criteria

It is the policy of Coordinated Care of Washington, Inc., in accordance with WAC 182-531-1600, that the only **covered** bariatric surgery for patients age >= 18 and < 21 years, is laparoscopic adjustable gastric banding (LAGB).

It is the policy of Coordinated Care of Washington, Inc., in accordance with WAC 182-550-2301, that bariatric surgery is **covered** only if the service is provided by a facility that is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)

It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Billing Guidelines and WAC 182-531-1600, that bariatric surgery is **medically necessary** when the following criteria under **sections I and II** are met**:**

I. **Stage 1-Requirements to enter Stage 2 of HCA process**, must meet all of the following:
   A. Age and medical history, meets all of the following:
      a. Member/enrollee age:
         i. 21-59; or
         ii. 18-20 years old for laparoscopic adjustable gastric banding (LAGB) only
      b. BMI of ≥ 35 kg/m²
      c. Member/enrollee is not pregnant. (Pregnancy within the first two years following bariatric surgery is not recommended. When applicable, a family planning consultation is highly recommended prior to bariatric surgery)
      d. Member/enrollee does not have any other medical conditions such as multiple sclerosis (MS) that would increase the risk of surgical mortality or morbidity from bariatric surgery
      e. Member/enrollee is diagnosed with One of the following:

i. Diabetes Mellitus
ii. Degenerative joint disease of a major weight bearing joint(s) (member/enrollee must be a candidate for joint replacement surgery if weight loss is achieved)
iii. Other rare comorbid conditions (such as pseudo tumor cerebri) in which there is medical evidence that bariatric surgery is medically necessary and that the benefits of bariatric surgery outweigh the risk of surgical mortality

Note: Coordinated Care may authorize up to 34 units of a bariatric case management service as part of the Stage II bariatric surgery approval. One unit of HCPCS code G9012 = 15 minutes of service. This fee is for the primary care provider or bariatric surgeon performing the services required for Bariatric Surgery Stage II. This includes overseeing weight loss and coordinating and tracking all the necessary referrals, which consist of a psychological evaluation, nutritional counseling, and required medical consultations.

II. **Stage 2-Preoperative evaluation and requirements** within 6 months of the scheduled surgery include *all* of the following (required for entering Stage 3 of HCA process):

Note: Coordinated Care will allow up to 12 months for completion of Stage 2 requirements if there is documentation of issues preventing completion of all requirements within the initial 6 months (i.e., provider access concerns). If the member/enrollee is unable to meet all of the stage 2 requirements within 12 months, a new authorization to re-enter stage 2 is required.

A. Member/enrollee must undergo a comprehensive psychosocial evaluation performed by a psychiatrist, licensed psychiatric ARNP, or licensed independent social worker with a minimum of two years postmasters' experience in a mental health setting. The comprehensive psychosocial evaluation must include all of the following:
    a. An assessment of the member/enrollee's mental status or illness to:
        i. Evaluate for the presence of substance abuse problems or psychiatric illness which would preclude the member/enrollee from participating in presurgical dietary requirements or postsurgical lifestyle changes; and
        ii. If applicable, document that the member/enrollee has been successfully treated for psychiatric illness and has been stabilized for at least six months and/or has been rehabilitated and is free from any drug and/or alcohol abuse and has been drug and/or alcohol free for a period of at least one year.
    b. An assessment and certification of the member/enrollee's ability to comply with the postoperative requirements such as lifelong required dietary changes and regular follow-up.
B. A pre-operative evaluation performed by a physician, board eligible or certified, in internal or family medicine to assess the member/enrollee's preoperative condition and mortality risk, including documentation of surgical clearance.
C. A surgical evaluation by the surgeon who will perform the bariatric surgery.
D. Member/enrollee must have documented weight loss of at least 5% of initial body weight within 6 months of the start of the stage 2 authorization and must maintain the 5% weight loss until surgery. The term "initial body weight" refers to the member/enrollee's weight at the first evaluation appointment.

E. Participation in a weight loss regimen prior to surgery. The purpose of the weight loss regimen is to help the member/enrollee achieve the required five percent weight loss prior to surgery and demonstrate ability to adhere to the radical and lifelong behavior changes and strict diet that are required after bariatric surgery. The weight loss regimen must meet *all* of the following requirements:
    a. Be supervised by a licensed medical provider
    b. Be at least six (6) months in duration
    c. Include monthly visits to the medical provider
    d. Include counseling twice a month by a registered dietician
    e. Documentation from the medical provider of the member/enrollee's compliance in keeping scheduled appointments and progress toward weight loss by serial weight recordings
    f. Documentation from the registered dietician of compliance (or noncompliance) in keeping scheduled appointments, and weight loss progress
    g. Documentation from the registered dietician that member/enrollee kept a journal of active participation in the medically structured weight loss regimen
    h. For members/enrollees with a history of Diabetes, the provider must document efforts for diabetic control or stabilization

III. Repeat Surgeries
A. Repeat bariatric surgery is considered medically necessary for one of the following:
    1. To correct complications from a previous bariatric surgery, such as obstruction or strictures (could include conversion surgeries to LSG or RYGB or BPD-DS);
    2. Conversion from LAGB to a LSG, RYGB or BPD-DS; or revision of a primary procedure that has failed due to dilation of the gastric pouch when all of the following criteria are met:
        a. All criteria listed above for the initial bariatric procedure must be met again;
        b. Previous surgery for morbid obesity was at least 2 years prior to repeat procedure;
        c. Weight loss from the initial procedure was less than 50% of the member/enrollee's excess body weight at the time of the initial procedure;
        d. If the conversion is requested due to removal of an eroded laparoscopic adjustable band, at least two months have passed between the band removal and the subsequent bariatric procedure;
        e. Documented compliance with previously prescribed postoperative nutrition and exercise program.
        f. Supporting documentation from the provider should also include a clinical explanation of the circumstances as to why the procedure failed.
    3. Conversion of SG to RYGB for the treatment of gastro-esophageal reflux disease (GERD) when anti-reflux medical therapy has been tried and failed.;
    4. Conversion of SG to RYGB or BPD-DS as a bridging procedure for BMI $\geq$ 50 kg/m^2.

IV. It is the policy of Coordinated Care of Washington, Inc., that the current medical literature is inadequate to determine the safety, efficacy and long-term outcomes for the following bariatric surgery procedures:
A. Distal gastric bypass (very long limb gastric bypass);
B. Loop Gastric Bypass ("Mini-Gastric Bypass");

C. Laparoscopic re-sleeve gastrectomy (LRSG) performed after the resulting gastric pouch is primarily too large or dilates after the original LSG;
D. Fobi pouch;
E. Laparoscopic greater curvature plication (Gastric Imbrication);
F. LAP-BAND when BMI is 30 to 35 with or without comorbid conditions;
G. Stomach aspiration therapy (e.g., AspireAssist);
H. Endoscopic Suture Revisions post bariatric surgery;
I. Single anastomosis duodenoileal bypass (SADI);
J. Gastric plication/ Endoluminal vertical gastroplasty;
K. Endoscopic gastrointestinal bypass devices (EGIBD (barrier devices);
L. One-anastomosis gastric bypass;
M. Endoscopic sleeve gastroplasty;
N. Transoral endoscopic surgery;
O. Vagus Nerve Blocking (e.g., Maestro);
P. Gastric balloon (e.g., ReShape Duo, Orbera intagastic balloon, Oblaon Balloon).

V. It is the policy of Coordinated Care of Washington, Inc., that that the following bariatric surgery procedures are considered **not medically necessary,** due to potential complications and a lack of positive outcomes:
A. Biliopancreatic diversion (BPD) procedure (also known as the Scopinaro procedure);
B. Jejunoileal bypass (jejuno-colic bypass);
C. Vertical Banded Gastroplasty (VBG);
D. Gastric pacing/gastric electrical stimulation;
E. Gastric wrapping.

Background

Persons with clinically severe obesity are at risk for increased mortality and multiple co-morbidities. These co-morbidities include hypertension, hypertrophic cardiomyopathy, hyperlipidemia, diabetes, cholelithiasis, obstructive sleep apnea, hypoventilation, degenerative arthritis and psychosocial impairments. The majority of severely obese patients losing weight through non-operative methods alone regain all the weight lost over the next five years. Surgical treatment is the only proven method of achieving long term weight control for the morbidly obese. Eating behaviors after surgery improve dramatically due to the restricted size of the stomach, allowing only small amounts of food to be taken in at a time.

The type of surgical procedure performed should be based on body mass index (BMI), comorbidity profile, treatment goals, surgeon's expertise, patient preference and risk stratification.[34] The most commonly performed bariatric procedure in the United States is laparoscopic sleeve gastrectomy (LSG), followed by laparoscopic Roux-en-Y gastric bypass (RYGB), laparoscopic adjustable gastric banding (LAGB), and Biliopancreatic diversion with duodenal switch (BPD-DS).[34] The sleeve gastrectomy (SG) continues to trend upwards due to lower rates of complications and nutritional deficiencies while maintaining comparable weight loss and metabolic disease outcomes.[34] It was the most commonly performed bariatric procedure in the United States and in the world in 2016, and laparoscopic surgery is the preferred methodology.[14]

The success of the bariatric surgery relies on the motivation and dedication to the program of the patient. The patient must be able to participate in the treatment and long-term follow up required after surgery. Studies have shown that about 10% of patients may have unsatisfactory weight loss or regain much of the weight they have lost. This may occur due to frequent snacking on high-calorie foods or lack of exercise. Technical problems that may occur include a stretched pouch due to overeating following surgery. Ensuring patients are motivated to lose weight can help prevent some of these issues.

Maximum weight loss usually occurs between 18 and 24 months postoperatively. The average weight loss at five years ranges from 48 to 74% after gastric bypass and 50 to 60% following gastric banding. Several studies have follow-up from five to 15 years with these patients maintaining weight loss of 50 to 60% of excess weight.

The Lap Band is a small bracelet-like band placed around the top of the stomach to produce a small pouch about the size of a thumb. The size of the outlet is controlled by a circular balloon inside the band that can be inflated and deflated with saline solution through an access port placed under the skin. The more inflated the balloon, the narrower the opening and slower passage of food to the rest of the stomach.

RYGB creates a small stomach pouch, bypassing most of the stomach, duodenum, and upper intestine. Weight loss occurs through restriction of food intake and by decreasing the absorption of food by re-routing food directly from the pouch into the small intestine. With over 25 years of experience with RYGB in adults, the long-term results are well established for weight loss and improvement in comorbidities, and this surgery now accounts for approximately 20% of bariatric procedures in adolescents.[27]

BPD-DS is a complex operation that includes removing a large portion of the stomach to promote smaller meal sizes, re-routing of food away from much of the small intestine to prevent partial absorption of food, and re-routing of bile and other digestive juices that impair digestion. The operation bypasses most of the duodenum but leaves a small portion for food and the absorption of some vitamins and minerals. BPD-DS produces significant weight loss but has a greater risk of long-term complications due to decreased absorption of food, vitamins, and minerals.

American Society for Metabolic and Bariatric Surgery (ASMBS)
Updated guidelines from the ASMBS recommend metabolic and bariatric surgery for patients with BMI $\geq$ 35 kg/m^2, regardless of presence, absence, or severity of co-morbidities and for patients with BMI of 30 to 34.9 kg/m^2 who do not achieve substantial, durable weight loss or co-morbidity improvement with reasonable nonsurgical methods, bariatric surgery should be considered. In this population, surgical intervention should be considered after failure of nonsurgical treatments. For patients with type two diabetes, bariatric and metabolic surgery is now recommended for those with BMI $\geq$ 30 kg/m^2. LAGB, LSG, and RYGB have been shown to be well-tolerated and effective treatments. Safety and efficacy of these procedures in low-BMI patients appear to be similar to results in patients with severe obesity. Currently, the best evidence for bariatric and metabolic surgery for patients with class I obesity and co-morbid conditions exists for patients in the 18 to 65 age group.[28, 36]

Bariatric Surgery in Adolescents
Weight loss surgery has been performed in small groups of adolescents since the 1970s. Recent data has shown a significant increase in the rate since 2000.[29] It is likely that we will continue to see a rise in the rate of adolescents undergoing weight loss surgery with the current pediatric obesity epidemic. Children and adolescents who are severely obese are at risk for the same mortality and co-morbidities as adults.[1,9] These co-morbidities include hypertension, hypertrophic cardiomyopathy, hyperlipidemia, diabetes, cholelithiasis, obstructive sleep apnea, depression and impaired quality of life. In addition, children in the BMI category ≥ 35 kg/m^2 will almost always remain obese, and 65% will have a BMI ≥ 40 as an adult.[27]

Changes in diet and physical activity must be attempted prior to weight loss surgery in adolescents. A multi-disciplinary, family-based approach should be undertaken to support a staged weight loss plan.[30] However, studies suggest that dietary and behavioral interventions rarely result in significant and sustained weight loss in adolescents. This same multi-disciplinary and family approach must be taken when evaluating and planning for bariatric surgery in an adolescent.[1,9]

Recently updated guidelines from the ASMBS on pediatric metabolic and bariatric surgery conclude that metabolic and bariatric surgery (MBS) is a proven, effective treatment for severe obesity disease in adolescents and should be considered standard of care. Treatment of severe obesity in adolescents clearly requires a multidisciplinary approach where MBS should not be consigned to the treatment of last resort. Rather, when considered appropriate and within the clinical best practice guidelines, MBS should be readily offered to adolescents with obesity to effectively reverse co-morbidities and achieve overall wellness. Prior weight loss attempts, Tanner stage, and bone age should not be barriers to definitive treatment.[29, 36]

Investigational Procedures
Long-limb or Distal Gastric Bypass for Superobesity: A randomized controlled trial (RCT) was completed by Svanevik et al., but only perioperative outcomes have been reported thus far. Svanevik et al. found that in superobese patients with BMI between 50 and 60 kg/m^2, distal gastric bypass was associated with longer operating time and more severe complications resulting in reoperation than proximal gastric bypass. There is increased risk of adverse nutritional outcomes with longer limb gastric bypass. At this time the long-limb or distal gastric bypass for superobesity is considered investigational, until more long-term studies can be done which reflect better outcomes than existing procedures.

Loop Gastric Bypass (Mini Gastric Bypass, one-anastomosis gastric bypass): The mini gastric bypass has not been universally accepted due to higher rates of alkaline bile reflux and limited long-term research. More long-term research is needed to solidify mini gastric bypass surgery's position as a viable bariatric surgery option.

Re-Sleeve Gastrectomy for Failed Laparoscopic Sleeve Gastrectomy: Iannelli et al. (2012) noted that laparoscopic sleeve gastrectomy (LSG) was rapidly accepted as a valuable bariatric procedure before its effectiveness on weight loss in the long-term is clearly demonstrated.[12] The authors report a feasibility study including 13 patients undergoing a redo LSG for either

progressive weight regain after initial weight loss or insufficient weight loss.[11] AlSabah et al. describe 24 patients who underwent re-sleeve laparoscopic gastrectomy after an initial LSG. Compared to 12 patients that initially had LSG, which was converted to LRYGB, results were similar, with no significant differences in percent of excess weight loss at one year.[2] They conclude that larger and longer follow-up studies are needed to verify results.[2]

Fobi Pouch or Silastic® Ring: The Fobi Pouch bariatric operation for obesity is a combination of stomach reduction and gastric bypass. The Silastic ring is placed around the vertically constructed gastric pouch above the anastomosis between the pouch and the intestinal Roux limb. Possible long term nutritional deficiencies involve fat soluble vitamin deficiencies of Calcium, Iron, B12, and Folic Acid. Patients are placed on nutritional supplements for the rest of their lives, and yearly monitoring is needed. The Fobi Pouch gastric bypass takes about double the time that a vertical banded gastroplasty operation takes. There is limited research on the outcomes of the Fobi pouch versus other bariatric surgery procedures.

Gastric Imbrication: Fried et al. (2011) completed a 3-year RCT on the safety and efficacy of laparoscopic adjustable gastric banding with and without imbrication sutures. The results of the RCT have demonstrated that SAGB combined with a conservative approach to band adjustments and limited retrogastric dissection is effective and safe with and without imbrication sutures. Not using imbrication sutures results in significant benefits in operative speed with comparable clinical weight loss and intermediate term safety. Sharma et al. conducted a randomized, double blinded trial comparing LSG and laparoscopic gastric imbrication (LGI). They found no differences in weight, age, or BMI preoperatively at 6 months or 3 years between the 2 groups.

The AspireAssist System (AspireAssist) was FDA approved in 2016. It is a weight loss device comprised of an endoscopically placed percutaneous gastrostomy tube and an external device to facilitate drainage of about 30% of each meal consumed. It is meant to be used in conjunction with diet and exercise. In 2017 a1-year RCT was performed comparing results of 207 patients treated with AspireAssist. The treatment group (n=137) received AspireAssist and lifestyle counseling, and the control group (n=70) received lifestyle counseling alone. Compared to the control group, those who received the AspireAssist and counseling lost more weight. 58.6% of participants in the AspireAssist group, and 15.3% of participants in the Lifestyle Counseling group lost at least 25% of their excess body weight ($P<0.001$). Additionally, a prospective observational study was conducted on 25 patients, and by the end of the 2-year observation period, only 15 patients were still in the study. They concluded that AspireAssist is an efficient and safe treatment for obesity. There is no research on AspireAssist versus other bariatric surgery procedures.

To enhance weight loss, the following endoscopic procedures have been attempted to promote restriction of the pouch or stoma. These revisions have included: sclerotherapy of the site using 6 to 30 mL of sodium morrhuate injected circumferentially; tissue plication systems to reduce the size of the gastrojejunostomy and the gastric pouch; revisional surgery using a tissue plication device known as StomaPhyX to reduce the pouch size; and application of the endoclip to reduce the size of the gastrojejunal anastomosis. There is a lack of long-term outcomes for endoscopic revisions post RYGB.

The single anastomosis duodenoileal bypass (SADI), also known as single-anastomosis duodenal switch (SADS) and most descriptively, single-anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S), combines restrictive, malabsorptive, and probably hormonal mechanisms for weight loss. The sleeve is created first, and the duodenum is divided after the pylorus. SADI creates an anastomosis between the side of the distal ileum and the end of the sleeve-like gastric pouch/duodenum.[14]

The ASMBS endorses SADI-S as an appropriate primary metabolic bariatric procedure.[14] Per the ASMBS, the SADI-S procedure is fundamentally a variant of the duodenal switch (DS) operation, in which the transected duodenum is anastomosed to a loop of ileum, as opposed to the classic DS in which a Roux-en-Y configuration is used. However, the ASMBS- notes the publication of long-term safety and efficacy outcomes is still needed and is strongly encouraged, particularly with published details on SG size and common channel length. There remain concerns about intestinal adaptation, nutritional issues, optimal limb lengths, and long-term weight loss/regain after this procedure. As such, ASMBS recommends a cautious approach to the adoption of this procedure, with attention to ASMBS-published guidelines on nutritional and metabolic support of bariatric patients, in particular for DS patients.[14,33]

The International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) considers SADI-S safe and effective based on short-term data from studies but recommends that long-term follow up be continued and that randomized controlled trials be performed in the near future.[33] In a 2021 updated statement, IFSO emphasized that SADI-S can result in maintaining significant weight loss for the obese individual, but nutritional deficiencies are a long-term safety concern, and patients need to be aware of this and encouraged to remain in long-term multidisciplinary care.[33]

Additionally, the National Institute for Health and Care and Excellence (NICE) encourages further research into SADI-S with a focus on long-term outcomes.[34] NICE recommendations also state that there are well-recognized complications when treating morbid obesity with SADI-S, including the possibility of serious metabolic complications.[34] NICE states, "this procedure should only be used with special arrangements for clinical governance, consent and audit or research."[34]

Endoluminal vertical gastroplasty/gastric plication is an endoscopic approach for suturing the stomach that offers the potential to perform gastric-restrictive procedures endoluminally. The anterior and posterior walls of the stomach are suctioned together, then held in place by either a stapler or T-fastener device to create a tube of stomach similar to the sleeve gastrectomy.

Endoscopic gastrointestinal bypass devices (EGIBD) are barrier devices deployed to prevent luminal contents from being absorbed in the proximal small intestine (e.g., ValenTX, EndoBarrier). Data are still lacking about the longevity of these endobarriers and their outcomes once the barrier is removed.

Not Medically Necessary Procedures
Biliopancreatic Diversion (BPD) Procedure (Scopinaro procedure): The biliopancreatic diversion (BPD) is a malabsorptive procedure that was introduced as a solution to the high rates of liver

failure resulting from bowel exclusion in the jejunoileal bypass. The procedure consists of a partial gastrectomy and gastroileostomy with a long segment of Roux limb and a short common channel, resulting in fat and starch malabsorption. BPD also has a restrictive component. The BPD/DS procedure differs from the BPD in the portion of the stomach that is removed, as well as preservation of the pylorus. This allows more forward flow of the contents of the biliopancreatic limb and avoids the complications of stasis that plagued the jejunoileal bypass (JIB). It is associated with fewer complications than BPD alone. BPD/DS is a complex procedure that is only performed at a few centers in the U.S.

Jejunoileal Bypass or Jejunoileal Intestinal Bypass (JIB): The jejunoileal bypass (also called the intestinal bypass) is performed by dividing the jejunum close to the ligament of Treitz and connecting it a short distance proximal to the ileocecal valve, thereby diverting a long segment of small bowel, resulting in malabsorption. This procedure is no longer performed due to the high complication rate and frequent need for revisional surgery. Per the American Society for Metabolic & Bariatric Surgery, the JIB is no longer a recommended bariatric surgical procedure. The lessons learned from the JIB include the crucial importance of long-term follow-up and the dangers of a permanent, severe and global malabsorption.

Vertical Banded Gastroplasty (VBG): VBG has fallen out of favor as a restrictive procedure for severe obesity, due largely to the advantages of adjustable gastric banding. VBG requires division of the stomach or intestinal resection, while LAGB does not. In addition, the staples used in VBG may break down and cause weight regain, and VBG requires the use of prosthetic mesh that may increase the incidence of stomach stenosis. Thus, CMS says in their National Coverage Determination for Bariatric Treatment for Morbid Obesity that “VBG procedures are essentially no longer performed.”

Gastric Balloon: Previous endoscopic technologies used to treat obesity endoscopically, such as the gastric balloon, had limited exposure in the U.S. and were removed from the market because of associated complications, such as balloon deflation with migration and resultant small intestinal obstruction.

Gastric Pacing: A number of procedures have been investigated for weight loss surgery but have not been totally accepted by the surgical community. Gastric pacing has been performed in several trials but has not been shown to have any long-term effect and has been abandoned.

Gastric Wrapping: A gastric wrap is minimally invasive surgery and involves folding the stomach in on itself and then the edges are stitched to turn the stomach into a narrow tube, therefore restricting the amount of food that can be consumed. This surgery is new and not widely offered, and there is a paucity of peer-reviewed scientific literature on this procedure.

Coding Implications

informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT codes that support medical necessity

CPT®* Codes	Description
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43770*	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
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)
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only

*Some codes may be used for both medically necessary and not medically necessary indications.

CPT codes that do not support medical necessity

CPT®* Codes	Description
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver

HCPCS codes that support medical necessity

HCPCS Codes	Description
G9012	Other Specified Case Management Service
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy adopted. Previous policy WA.UM.30 archived in April 2019	07/19	09/19
Restructured criteria in section I. Medical History. Moved codes 43842 and 43847 to table of codes that do not support medical necessity. Added the following codes to the table that does not support medical necessity: 43647, 43881, 64590. In glycemic control section, changed HbA1C requirement to <7% instead of 6.5-7%. Noted that glycemic control requirement doesn't apply to those who qualify for surgery based on BMI between 30 and 35 with type 2 DM.	09/19	09/19
Restructure criteria in section I to more closely mirror corporate policy. Changes to section III. Repeat surgeries: Clarified in III.A.1. that repair of complications could include revisions to LSG or RYGB or to BPD-DS. Added to III.A.2 that LSG was an acceptable revision procedure. Added criteria to III.A.2.d. that if the conversion is requested due to	02/20	03/20

Reviews, Revisions, and Approvals	Revision Date	Approval Date
removal of an eroded laparoscopic adjustable band, at least two months have passed between the band removal and the subsequent bariatric procedure. Added indication in III.A.3 for conversion of sleeve gastrectomy to Roux-en-Y gastric bypass for the treatment of gastro-esophageal reflux disease (GERD) when anti-reflux medical therapy has been tried and failed. Added reference to MBSAQIP certified facility.		
Added coronary artery disease as a comorbidity under A.1.b.ii. Edits made to ICD-10 codes; M54-M54.9 now M54.00-M54.9; T81.1X+-T81.9X now T81.10X+ - T81.9XX+; and T85.59 – T85.59 now T85.590+ - T85.598+. References reviewed and updated. Updated coverage statement to reflect WAC that allows only laparoscopic gastric band procedures for adults 18-21 years of age.	07/20	08/20
Specified that H. Pylori screening should be conducted using a urea breath test or stool antigen test. Added the following ICD-10 code ranges: M17.0-M17.9, M19.171-M19.179 and M19.271-M19.279. 10/1/20 ICD 10 updates: Replaced category K21.0-K21.9 with K21.00-K21.9. Removed "member" from II.C.4. and II.G. Reworded II.G with no impact on criteria. Replaced "member" with "member/ enrollee" in all other instances. Add guidance around case management. Updated references.	11/20	12/20
Section I: Added note about stage of process. Added BMI criteria for Asian ethnicity to I.B.1. and I.B.3. Section II: Added note about stage of process. Removed criteria for ECG during cardiac clearance except for high risk, corrected typos; in II.B, added note about medical director review if A1C ≥8 and removed blood glucose requirements; in II.C., Pulmonary Evaluation removed requirement of chest x-ray and specific criteria for PSG, noting that PSG is warranted if OSA screening is positive in; In II.D, added examples of nutritional tests to be conducted, and that malabsorptive procedures may require further testing; Removed requirement of 1 year abstinence of drug & alcohol use and urine drug screen if history of abuse in II.F; added "current drug and alcohol abuse" to list of contraindications; added II.I, clinically significant GI symptoms should be evaluated & treated prior to surgery. In III.A.2.e, removed option for non-compliance with post-operative regimen if completing a multidisciplinary bariatric program. In III.A.2.f., removed option for non-compliance. Reworded V, replacing "investigational" with "current medical literature is inadequate to determine the safety, efficacy and long-term outcomes" and added one-anastomosis gastric bypass; endoscopic sleeve gastroplasty; transoral endoscopic surgery; vagus nerve blocking (e.g., Maestro) and gastric balloon (e.g., ReShape Duo, Orbera intagastic balloon, Obalon Balloon) to this list. Updated background. Added the following CPT codes as not supporting medical necessity: 43648, 43882, 64595, 0312T, 0313T, 0314T, 0315T, 0316T	07/21	08/21

Reviews, Revisions, and Approvals	Revision Date	Approval Date
and 0317T. References reviewed, updated and reformatted. Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date."		
Annual review. Moved note about G9012 into section I. Description updated with no impact on criteria. Criteria I.A. procedures listed with abbreviations with no impact on criteria. Background updated with no impact on criteria. Corrected ICD10 code I10.0 to I10. References reviewed and updated.	06/22	07/22
Annual review. Updated policy format. Updated policy statement in I, I.A.1 updated policy statement and BMI threshold to ≥ 35 or ≥ 32.5 kg/m2 for South Asian, Southeast Asian, and East Asian adults. BMI threshold was updated to "BMI ≥ 30 and < 35 kg/m², or < 27.5 kg/m2 and < 32.5 kg/m2 for South Asian, Southeast Asian, and East Asian adults. Type 2 diabetes mellitus (DM) as an absolute co-morbidity. Added "pseudotumor cerebri" and "disqualification from other surgeries...". Removed criteria requiring prescribed exercise program as part of nutritional counseling. Moved Contraindications to I.C and added "severe cardiac disease with prohibitive anesthetic risks," "uncontrolled and untreated eating disorders (eg, bulimia)," "inability on the part of the patient or parent/guardian to comprehend the risks and benefits of the surgical procedure," and "a medical, psychiatric, psychosocial, or cognitive condition that prevents adherence to postoperative dietary and medication regimens or impairs decisional capacity." Background updated with no clinical impact. Removed deleted CPT codes 0312T-0317T and added CPT codes 43290, 43291, and 43632 to not medically necessary table. Removed ICD-10 codes and table. References reviewed and updated. Reviewed by internal and external specialists. Section III: updated abbreviations in III.3 with no clinical significance; added indication for SG to RYGB or BPD-DS DS as a bridging procedure for BMI ≥ 50 kg/m² in III.4.	04/23	04/23
Revised policy sections I and II to mirror WAC 182-531-1600 requirements. Added note to section II indicating extensions may be granted to 6 month time period. Removed section III. Contraindications for surgical weight loss procedures, as this is a standard part of bariatric COE pre-operative evaluations.	05/23	05/23
Modified section II.B. to allow family practice in addition to internal medicine physicians conduct pre-operative assessments.	10/23	10/23

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program

approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take

precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.