

Corporate Medical Policy

Surgery for Morbid Obesity

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Description of Procedure or Service

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

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

The following summarizes the different restrictive and malabsorptive procedures.

Gastric Restrictive Procedures

1. Vertical-Banded Gastroplasty (CPT code 43842) Vertical-banded gastroplasty was formerly one of the most common gastric restrictive procedures performed in this country but has more recently declined in popularity. In this procedure, the stomach is segmented along its vertical axis. To create a durable reinforced and rate-limiting stoma at the distal end of the pouch, a plug of stomach is removed, and a propylene collar is placed through this hole and then stapled to itself. Because the normal flow of food is preserved, metabolic complications are uncommon. Complications include esophageal reflux, dilation, or obstruction of the stoma, with the latter two requiring reoperation. Dilation of the stoma is a common reason for weight regain. Vertical-banded gastroplasty may be performed using an open or laparoscopic approach.
2. Adjustable Gastric Banding (CPT code 43770) Adjustable gastric banding involves placing a gastric band around the exterior of the stomach. The band is attached to a reservoir that is implanted subcutaneously in the rectus sheath. Injecting the reservoir with saline will alter the diameter of the gastric band; therefore, the rate-limiting stoma in the stomach can be progressively narrowed to induce greater weight loss, or expanded if complications develop. Because the stomach is not entered, the surgery and any revisions, if necessary, are relatively simple. Complications include slippage of the external band or band erosion through the gastric wall. Adjustable gastric banding has been widely used in Europe; currently, one such device is approved the FDA for marketing in the U.S, the Lap-Band (BioEnterics, Carpinteria, CA). The labeled indications for this device are as follows:

"The Lap-Band system is indicated for use in weight reduction for severely obese patients with a body mass index (BMI) of at least 40 or a BMI of at least 35 with one or more severe comorbid conditions, or those who are 100 lbs or more over their estimated ideal weight according to the 1983 Metropolitan Life Insurance Tables (use the midpoint for

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medium frame). It is indicated for use only in severely obese adult patients who have failed more conservative weight-reduction alternatives, such as supervised diet, exercise and behavior modification programs. Patients who elect to have this surgery must make the commitment to accept significant changes in their eating habits for the rest of their lives."

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

"The [REALIZE] device is indicated for weight reduction for morbidly obese patients and is indicated for individuals with a BMI of at least 40 kg/m², or a BMI of at least 35 kg/m² with one or more comorbid conditions. The band is indicated for use only in morbidly obese adult patients who have failed more conservative weight-reduction alternatives, such as supervised diet, exercise, and behavior modification programs."

3. **Open Gastric Bypass (CPT code 43846)** The original gastric bypass surgeries were based on the observation that post-gastrectomy patients tended to lose weight. The current procedure involves both a restrictive and a malabsorptive component, with horizontal or vertical partition of the stomach performed in association with a Roux-en-Y procedure (i.e., a gastrojejunal anastomosis). Thus, the flow of food bypasses the duodenum and proximal small bowel. The procedure may also be associated with an unpleasant "dumping syndrome," in which a large osmotic load delivered directly to the jejunum from the stomach produces abdominal pain and/or vomiting. The dumping syndrome may further reduce intake, particularly in "sweets eaters." Operative complications include leakage and marginal ulceration at the anastomotic site. Because the normal flow of food is disrupted, there are more metabolic complications compared to other gastric restrictive procedures, including iron deficiency anemia, vitamin B-12 deficiency, and hypocalcemia, all of which can be corrected by oral supplementation. Another concern is the ability to evaluate the "blind" bypassed portion of the stomach. Gastric bypass may be performed with either an open or laparoscopic technique.

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

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

5. **Mini-Gastric Bypass (no specific CPT code)** Recently, a variant of the gastric bypass, called the mini-gastric bypass, has been popularized. Using a laparoscopic approach, the stomach is segmented, similar to a traditional gastric bypass, but instead of creating a Roux-en-Y anastomosis, the jejunum is anastomosed directly to the stomach, similar to a Billroth II procedure. This unique aspect of this procedure is not based on its laparoscopic approach but rather the type of anastomosis used. It should also be noted that CPT code 43846 does not accurately describe the mini-gastric bypass, since CPT code explicitly describes a Roux-en-Y gastroenterostomy, which is not used in the mini-gastric bypass.

6. **Sleeve gastrectomy (CPT code 43775)**. A "sleeve" gastrectomy is an alternative approach to gastrectomy that can be performed on its own, or in combination with malabsorptive procedures (most commonly biliopancreatic diversion with duodenal switch). In this procedure, the greater curvature of the stomach is resected from the angle of His to the distal antrum, resulting in a stomach remnant shaped like a tube or "sleeve". The pyloric sphincter is preserved, resulting in a more physiologic transit of food from the stomach to the duodenum, and avoiding the "dumping syndrome" (overly rapid transport of food through stomach into intestines) that is seen with distal gastrectomy. This procedure is relatively simple to perform, and can be done by the open or laparoscopic technique. Some surgeons have proposed this as the first in a two-stage procedure for very high-risk patients. Weight loss following sleeve gastrectomy may improve a patient's overall medical status, and thus reduce the risk of a subsequent more extensive malabsorptive procedure, such as biliopancreatic diversion.

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Endoluminal (also called endosurgical, endoscopic, or natural orifice) bariatric procedures. With these procedures access to the relevant anatomical structures is gained through the mouth without skin incisions. Primary and revision bariatric procedures are being developed to reduce the risks associated with open and laparoscopic interventions. Examples of endoluminal bariatric procedures studies include gastroplasty using a transoral endoscopically guided stapler and placement of devices such as a duodenal-jejunal sleeve and gastric balloon.

Malabsorptive Procedures

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

1. Biliopancreatic Bypass Procedure (also known as the Scopinaro procedure) (CPT code 43847).

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

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

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

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

3. Long-Limb Gastric Bypass (i.e., >150 cm) (CPT code 43847) Recently, variations of gastric bypass procedures have been described, consisting primarily of long-limb Roux-en-Y procedures, which vary in

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the length of the alimentary and common limbs. For example, the stomach may be divided with a long segment of the jejunum (instead of ileum) anastomosed to the proximal gastric stump, creating the alimentary limb. The remaining pancreaticobiliary limb, consisting of stomach remnant, duodenum, and length of proximal jejunum is then anastomosed to the ileum, creating a common limb of variable length in which the ingested food mixes with the pancreaticobiliary juices. While the long alimentary limb permits absorption of most nutrients, the short common limb primarily limits absorption of fats. The stomach may be bypassed in a variety of ways, i.e., either by resection or stapling along the horizontal or vertical axis. Unlike the traditional gastric bypass, which is essentially a gastric restrictive procedure, these very long-limb Roux-en-Y gastric bypasses combine gastric restriction with some element of malabsorptive procedure, depending on the location of the anastomoses. Note that CPT code for gastric bypass (43846) explicitly describes a short limb (<150 cm) Roux-en-Y gastroenterostomy, and thus would not apply to long-limb gastric bypass.

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

****Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.*

Policy

BCBSNC will provide coverage for surgery for morbid obesity when it is determined to be medically necessary because the medical criteria and guidelines shown below are met. Also see Policy Guidelines.

Benefits 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. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

Surgery for Morbid Obesity requires prior review.

When Surgery for Morbid Obesity is covered

- I. Criteria for Adults - Surgery for Morbid Obesity is covered when all five of the following criteria are met:
 - A. The patient must have morbid obesity as defined below:
 1. have a BMI \geq 40 (Refer to BMI table on pages 13 and 14) or
 2. have a BMI \geq 35 associated with at least one or more of the following problems which are generally expected to be improved, curtailed or reversed by surgical treatment:
 - a. The obesity interferes with daily function to the extent that performance is severely curtailed (i.e., impending job loss or job loss with documented disability); or
 - b. The obesity causes incapacitating pain and limitation of motion in any weight-bearing joint or the lumbosacral spine documented by physical examination in association with radiologic findings showing degenerative osteoarthritis; or
 - c. There is significant respiratory insufficiency as evidenced by pCO₂ > 50 mmHg, hypoxemia at rest, as evidenced by pO₂ < 55 mmHg on room air; FEV₁/FVC < 65%, or DLCO < 60% (e.g., Obesity Hypoventilation Syndrome); or
 - d. Clinically significant obstructive sleep apnea (i.e., Patient meets criteria for treatment of obstructive sleep apnea set forth in a separate policy, titled Sleep Apnea and Breathing Related Sleep Disorders in Adults); or
 - e. Type 2 diabetes mellitus; or
 - f. Documented coronary artery disease; or
 - g. Cardiomyopathy; or

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- h. Heart failure; or
 - i. Gastroesophageal reflux disease with secondary asthma or erosive esophagitis not controlled despite maximum dosages of proton pump inhibitors; or
 - j. Pseudotumor cerebri; or
 - k. Patient has at least one of the following:
 - i. Medically refractory hypertension (blood pressure > 140 mmHg systolic and/or > 90 mmHg diastolic measured with appropriate size cuff) that has not responded to medical management including at least two (2) anti-hypertensive drugs at maximum tolerated dosages.
 - ii. First degree relative with premature (age < 50) cardiovascular disease.
 - iii. Hypercholesterolemia > 240 mg/dL or hypertriglyceridemia > 400 mg/dL or low density lipoprotein (LDL) \geq 160 mg/dL or high density lipoprotein (HDL) < 40 mg/dL; despite appropriate medical therapy defined as at least one appropriate drug at maximum dosage.
 - iv. Metabolic syndrome.
 - v. Pulmonary hypertension; AND
 - B. Morbid obesity (BMI > 35 associated with at least one of the problems listed in A.1.b. or BMI > 40) has been present for at least the previous two years; AND
 - C. The patient has no specifically correctable cause for the obesity, e.g., an endocrine disorder; AND
 - D. A thorough evaluation (see Policy Guidelines section) has been documented to assess the patient's suitability for surgery and their ability to comply with lifelong follow up; AND
 - E. Surgery for morbid obesity is eligible for coverage when it is part of a comprehensive pre-surgical, surgical and post-surgical program (see Policy Guidelines Section).
- II. **Criteria for Adolescents < 18 years of age:**
Coverage for adolescents under 18 years of age may be provided only in a covered clinical trial offering a multidisciplinary team approach capable of managing the unique challenges posed by the adolescent age group. For the purpose of this policy, severe adolescent morbid obesity is considered a life threatening condition. (Refer to Clinical Trial policy for other criteria a covered clinical trial must meet.)
- III. **Surgical Procedures - The following surgical procedures are considered eligible for coverage for the morbidly obese individual who meets the preceding criteria:**
- A. Short limb Roux-en-Y - involves creating a small stomach pouch. A short limb of small bowel (150 cm or less) is divided and anastomosed to the small stomach pouch, bypassing a large part of the stomach and duodenum.
 - B. Long limb Roux-en-Y, involving more than 150 cm of the small intestine, will be reviewed on an individual consideration basis (typically considered for patients with BMI equal to or greater than 55).
 - C. Adjustable Gastric Banding - Additional criteria include the following:
 - 1. Adult patients (Patients 18 years of age or older). FDA approval for the LAP-BAND[®] Adjustable Gastric Banding (LAGB[®]) System indicates it is for use only in severely obese adult patients. It is contraindicated in non-adult patients (patients under 18 years of age). The REALIZE[™] Adjustable Gastric Band is indicated for use only in morbidly obese adult patients.
 - D. Biliopancreatic bypass with or without duodenal switch may be considered on an individual consideration basis for patients with a BMI > 50.
- IV. **Revision Bariatric Surgery. -**
- A. Revision surgery to address perioperative or late complications of a bariatric procedure is considered medically necessary. These include, but are not limited to, staple-line failure, obstruction, stricture, non-absorption resulting in hypoglycemia or malnutrition, weight loss of 20% or more below ideal body weight.
 - B. Revision of a primary bariatric procedure that has failed due to dilation of the gastric pouch (documented by upper gastrointestinal examination or endoscopy) is considered medically necessary if the initial procedure was successful in inducing weight loss prior to pouch dilation and the patient has been compliant with a prescribed nutrition and exercise program and the patients still meets criteria (BMI) for bariatric surgery.

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When Surgery for Morbid Obesity is not covered

Surgery for Morbid Obesity is not covered in the following situations:

1. When the preceding criteria for coverage are not met;
2. When the procedure is considered *investigational*, including but not limited to:
 - a. Jejunioileal bypass - any surgical procedure that shunts ingested food from the jejunum into the ileum thus bypassing a majority of the small intestine.
 - b. Biliopancreatic bypass (except as noted above).
 - c. Gastric wrapping - a surgical procedure in which the stomach is folded over on itself and a full stomach wrap (polypropylene mesh) is applied. The outcome is to limit gastric volume.
 - d. Adjustable Gastric Banding in non-adult patients (patients under 18 years of age);
 - e. Jejunocolostomy - a surgical procedure that entails anastomosis of the end of the jejunum to the mid-transverse colon thus creating a short bowel syndrome.
 - f. Sleeve gastrectomy, either as a stand-alone procedure or as the first step in a planned staged procedure for high-risk, super-obese patients.
 - g. Gastric bypass using a Billroth II type of anastomosis, popularized as the mini-gastric bypass.
 - h. Gastric electrical stimulation. (Refer to separate policy of the same name.)
 - i. Garren-Edwards Gastric Bubble (aka, intra-gastric balloon).
 - j. Roux-en-Y is not indicated for a failed Nissen Fundoplasty unless the patient meets the other criteria for surgery for morbid obesity.
 - k. Endoscopic procedures (e.g., insertion of the StomaphyX™ device) as a primary bariatric procedure or as a revision procedure, i.e., to treat weight gain after bariatric surgery to remedy large gastric stoma or large gastric pouches.
 - l. As a cure for type 2 diabetes mellitus.
3. Vertical-banded gastroplasty was once the most common type of gastric restrictive procedure performed in the U.S., but has fallen out of favor due to a high reoperation rate. Therefore, vertical-banded gastroplasty is no longer a standard of care and is therefore considered not medically necessary.

If it is determined that the surgery for morbid obesity is not medically necessary or investigational, and the gallbladder is removed during the same operative session, the removal of the gallbladder would not be covered.

Policy Guidelines

A thorough preoperative evaluation for surgery for morbid obesity must include all of the following:

1. Evaluation of the patient's understanding of the procedure to be performed, including the procedure's risks and benefits, length of stay in the hospital, behavioral changes required prior to and after the surgical procedure (including dietary and exercise requirements), follow up requirements with the performing surgeon, and anticipated psychological changes.
2. Evaluation of the patient's family/caregivers support and understanding of the information in #1.
3. Within 12 months prior to surgery, a thorough nutritional evaluation by a physician or registered dietician experienced in the issues of bariatric surgery, who has had a meaningful conversation with the individual regarding the dietary and lifestyle changes required to ensure a successful outcome over time.
4. Evaluation by a licensed psychologist, psychiatrist or licensed clinical social worker that documents the absence of significant psychopathology that can limit the patient's understanding

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of the procedure or the ability to comply with medical/surgical recommendations and to adhere to required lifestyle modifications and follow up/ social support. Documentation from that evaluation must include the patient's suitability for the proposed bariatric surgery and the lifetime commitment required for a successful outcome.

5. Appropriate medical work up may include a chest x-ray, upper gastrointestinal series, endoscopy, appropriate pre-op labs and ECG. A complete physical examination by the attending surgeon and an assessment of thyroid levels is required. If the patient has comorbid conditions (e.g. diabetes or cardiovascular disease) the patient must be capable of undergoing the procedure.
6. Anesthesia clearance for surgery.

The first five criteria must be met before seeking prior plan approval; the sixth must be met prior to surgery.

Surgical procedures must be performed at a facility capable of providing gastrointestinal and biliary surgery (preferably JCAHO accredited), AND that has equipment and staff capable of managing a morbidly obese patient (appropriate instruments, beds, lifts, monitoring equipment) AND that can manage short and long term complications of surgery for morbid obesity.

The performing surgeon must be qualified and experienced in performing the procedure to be undertaken.

Follow up programs must include regular follow up for at least five years.

Significant weight loss following surgery for morbid obesity can lead to redundant skin and fat folds in varied anatomic locations (e.g., breasts, medial upper arms, and medial thighs, lower abdominal area also called "abdominal apron" or pannus). Surgical removal of redundant skin and fat folds is generally considered cosmetic and is not covered. Coverage may be considered for panniculectomy in patients who meet criteria specified in separate policy, Cosmetic and Reconstructive Surgery.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: 43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, S2083, 43659

There is no specific code describing the Mini-Gastric Bypass procedure. Providers should bill the most appropriate unlisted code (i.e., CPT code 43659).

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

Committee on Blue Shield, March 1983

BCBSA Medical Policy Reference Manual - 7/96

Milliman & Robertson Healthcare Management Guidelines. December 1997. Vol. 1. Pg. 3.17-3.18. Gastric Surgery for Clinically Severe Obesity.

Medical Policy Advisory Group - 5/99

Specialty Matched Consultant Advisory Panel - 11/2000

Medical Policy Advisory Group review - 3/1/2001

Medical Policy Advisory Group - 6/2001

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Specialty Matched Consultant Advisory Panel - 8/2002

BCBSA Medical Policy Reference Manual, 7.01.47; 7/17/03

BCBSA Medical Policy Reference Manual, 7.01.47; 12/17/03

Specialty Matched Consultant Advisory Panel - 8/2004

Medical Policy Advisory Group - 9/16/04

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.47, 11/9/04

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.47; 12/14/05

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.47; 7/20/06

BCBSA Technology Assessment Program, Volume 20, No. 5. August 2005. Newer Techniques in Bariatric Surgery for Morbid Obesity: Laparoscopic Adjustable Gastric Banding, Biliopancreatic Diversion, and Long-Limb Gastric Bypass. Retrieved on August 16, 2006 from: http://www.bcbsa.com/tec/vol20/20_05.html

BCBSA Technology Assessment Program, Volume 20, No. 15, February 2006. Laparoscopic Gastric Bypass Surgery for Morbid Obesity. Retrieved on August 16, from: http://www.bcbsa.com/tec/vol20/20_15.html

Specialty Matched Consultant Advisory Panel - 8/2006

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.47; 12/12/06

U.S. Food and Drug Administration. Approval Order, Summary of Safety and Effectiveness, Labeling and other consumer information. Retrieved on 1/11/07 from <http://www.fda.gov/cdrh/pdf/p000008.html>

Grundy SM, Brewer HB, Cleeman JI, Smith SC, Lenfant D, for the Conference Participants. Definition of metabolic syndrome: report of the National, Heart, Lung, and Blood Institute/American Heart Association conference on scientific issues related to definition. *Circulation*. 2004;109:433-438. Retrieved on May 14, 2008 from <http://www.circ.ahajournals.org/cgi/content/full/109/3/433>.

Gundy SM, Cleeman JI, Daniels SR, Donato KA, Eckel RH, Franklin BA, et al. (2005). Diagnosis and Medical Management of the Metabolic Syndrome: An American Heart Association/National Heart, Lung, and Blood Institute Scientific Statement: Executive Summary. *Circulation* 2005;112:e285-e290. Retrieved on May 6, 2008 from <http://www.circ.ahajournals.org/cgi/content-nw/full/112/17/e285>

Mokhlesi B, Kryger MH, Grunstein RR, (2008). Assessment and Management of Patients with Obesity Hypoventilation Syndrome. *The Proceedings of the American Thoracic Society*. 5:218-225 (2008). Retrieved on July 14, 2008 from <http://pats.atsjournals.org/cgi/content/full/5/2/218>

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.47; 2/14/08

Bariatric Physician Advisory Panel - 7/17/08

Specialty Matched Consultant Advisory Panel - 9/4/08

Bariatric Physician Advisory Panel - 1/7/09

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.47, 1/14/10

Policy Implementation/Update Information

5/83	Original policy issued.
5/95	Revised: coding changes.
9/96	Revised: Combined Local and National policies.
11/96	Reaffirmed.

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- 4/99 Policy updated with Milliman & Robertson Surgical Authorization Guidelines from the December 1997 Healthcare Management Guidelines Vol. Added no correctable cause for obesity and patient has attained full growth criteria.
- 5/99 Medical Policy Advisory Group
- 6/99 Reformatted, Medical Term Definitions added.
- 9/00 Policy criteria reviewed for clarity. Re-outlined to clarify criteria requirements. System coding changes.
- 01/01 Specialty Matched Consultant Advisory Panel 11/00. BMI added to criteria.
- 3/01 Policy updated to indicate that the Mini-Gastric Bypass is considered investigational. Medical Policy Advisory Group meeting 3/1/2001. Approve.
- 6/01 Medical Policy Advisory Group.
- 7/01 Medical Policy Advisory Group recommended changes to criteria. Revised criteria to eliminate specific reference to medical weight loss programs as a requirement for surgery for morbid obesity and added criteria for evaluation and documentation of the patient's ability to comply with lifelong follow up. System coding changes.
- 11/01 Added the following criteria for coverage of Surgery for Morbid Obesity: "Gastric Bypass, involving more than 100 cm but less than 160 cm of the small intestine, will be reviewed on an individual consideration basis."
- 4/02 Revised. Changed A. under when it is covered to include "all six" criteria must be met. Added statement number six to include, "Surgery for morbid obesity is eligible for coverage when it is part of a comprehensive pre-surgical and post-surgical program".
- 9/02 Clarified statement to indicate that this procedure may require Prior Plan Approval.
- 3/03 Specialty Matched Consultant Advisory Panel review - 8/15/02. System coding changes.
- 4/03 The following were omitted from the 3/03 entry above. Under "When Covered" A.1.b.iii - added sleep apnea documented by sleep studies; added A.1.b.iv - Poorly controlled hypertension despite medication; B.2. added "(typically considered for patients with BMI equal to or greater than 55)". Added Body Mass Index definition to Medical Term Definition section. Added statement regarding redundant skin and fat folds to Policy Guidelines section. Also referred to Cosmetic and Reconstructive Surgery policy.
- 5/03 Policy reformatted for clarity. Under "When Covered section": A.1.a. - Changed BMI>40 to BMI≥40; A.1.b - Statement revised to "have a BMI≥35..."; A.1.b.v. - Added hypertension, etc. is significantly complicated by morbid obesity.; A.1.b.vi. - deleted; B. - Added #4. Policy Guidelines revised to provide details re: comprehensive pre-surgical, surgical and post-surgical program. Tables 1-6 deleted and BMI Table added. Key words added.
- 4/22/04 Under "Description of Procedure" reversed position of malabsorptive procedures and gastric restrictive procedures. Under "When Covered" the following changes were made: A.1.a. - deleted "at least 100% overweight". Policy is referencing BMI rather than weight. A.1.b.v. - added "(e.g. requiring prescription drug treatment)". A.2 changed to "Morbid obesity (BMI ≥ 35 associated with at least one of the problems listed in A.1.b. or BMI ≥ 40) has been present for four of the previous five years." A.4. - added "(for adolescents-bone age shows closure of epiphyseal plates)". A.5. - added "(see Policy Guidelines section)". Under "Policy Guidelines" the following changes were made: In second sentence, "adequate" changed to "thorough". Number 4, Psychological assessment - changed wording following "to include" to "assessment of any diagnosable mental health conditions that may affect treatment, readiness and ability to adhere to required lifestyle modifications and follow up/social support". Following numbers 1) through 6) added "The first four criteria above must be met before seeking prior plan approval, the last two criteria must be met prior to surgery." Benefits Application and Billing/Coding sections revised. CPT code 43659 added to Billing/Coding section as this code may be billed

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for the Mini-Gastric Bypass procedure. Also added HCPCS codes S2082 and S2085. Notification given 4/22/04. Effective date 7/1/04.

- 10/28/04 Specialty Matched Consultant Advisory Panel review 8/2004. Medical Policy Advisory Group review 9/16/04. Added HCPCS code S2083 No changes to the policy.
- 12/23/04 Codes 43644, 43645, 43845 added to Billing/Coding section of policy.
- 2/02/06 Removed deleted codes S2082 & S2085 from Billing/Coding section and added 2006 CPT codes 43770, 43771, 43772, 43773, 43774, 43886, 43887, & 43888.
- 11/13/06 Description section revised to include detailed description of surgical procedures for morbid obesity. **When covered** section revisions: Removed B.3. Vertical-banded gastric partition (also called vertical banded gastroplasty); Added C. Reoperation and Surgical Revision which includes the most common complications/conditions/diagnoses for which reoperation or surgical revisions are performed. **When not covered** section revisions: Added 2.f. Sleeve gastrectomy, either as the sole procedure or as one step in a staged procedure; 2.g. Gastric bypass using a Billroth II type of anastomosis, popularized as the mini-gastric bypass (this replaced the previous wording re: mini-gastric bypass which was removed); 2.h. Gastric electrical stimulation; 2.i. Garren-Edwards Gastric Bubble (aka, intra-gastric balloon); 2.j. Roux-en-Y is not indicated for a failed Nissen Fundoplasty unless the patient meets the other criteria for surgery for morbid obesity; 3. Vertical-banded gastroplasty was once the most common type of gastric restrictive procedure performed in the U.S., but has fallen out of favor due to a high reoperation rate. Therefore, vertical-banded gastroplasty is no longer a standard of care and is therefore considered not medically necessary. Reference sources and medical terms added. Notification given 11/13/06. Effective date 1/17/07. (pmo)
- 1/29/07 Covered and non-covered criteria added for adjustable gastric banding. Reference source added. (pmo)
- 2/12/07 Added the following to **When covered** section: B.4 Biliopancreatic bypass with or without duodenal switch may be considered on an individual consideration basis for patients with a BMI>50. This was inadvertently deleted during the 1/29/07 revisions. (pmo)
- 6/4/07 Reference source added. (pmo)
- 10/6/08 "**When Covered**" section revisions:

Section A: Criteria for *Adults*...A.1.b. have a BMI ≥ 35 associated with at least one or more of the following problems *which are generally expected to be improved, curtailed or reversed by surgical treatment*: Revisions under A.1.b: ii The obesity causes incapacitating *pain and limitation of motion in any weight-bearing joint or the lumbosacral spine* documented by *physical examination in association with radiologic findings showing degenerative osteoarthritis*; iii. There is significant respiratory insufficiency *as evidenced by pCO₂ > 50 mmHg, hypoxemia at rest, as evidenced by pO₂ < 55 mmHg on room air; FEV₁/FVC < 65%, or DLCO < 60% (e.g., Obesity Hypoventilation Syndrome)*; iv. Clinically significant obstructive sleep apnea (i.e., Patient meets criteria for treatment of obstructive sleep apnea set forth in policy number OTH8138, titled Sleep Apnea and Breathing Related Sleep Disorders in Adults); v. Type 2 diabetes mellitus; vi. Documented coronary artery disease; vii. Cardiomyopathy; viii. Heart failure; ix. Gastroesophageal reflux disease with secondary asthma or erosive esophagitis not controlled despite maximum dosages of proton pump inhibitors; x. Pseudotumor cerebri; xi. Patient has at least one of the following: Medically refractory hypertension (blood pressure > 140 mmHg systolic and/or > 90 mmHg diastolic measured with appropriate size cuff) that has not responded to medical management including at least two (2) anti-hypertensive drugs at maximum tolerated dosages; First degree relative with premature (age < 50) cardiovascular disease; Hypercholesterolemia > 240 mg/dL or hypertriglyceridemia > 400 mg/dL or low density lipoprotein (LDL) ≥ 160 mg/dL or high density lipoprotein (HDL) < 40 mg/dL; despite appropriate medical therapy defined as at least one appropriate drug at maximum dosage; Metabolic syndrome; Pulmonary hypertension. A.4. has been deleted

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~~"Patient has achieved full growth (for adolescents bone age shows closure of epiphyseal plates.~~

Section B. is now "Criteria for Adolescents < 18 years of age: Coverage for adolescents under 18 years of age may be provided only in a covered clinical trial offering a multidisciplinary team approach capable of managing the unique challenges posed by the adolescent age group. For the purpose of this policy, severe adolescent morbid obesity is considered a life threatening condition. Refer to Clinical Trial policy (MED1093) for other criteria a covered clinical trial must meet.

Section C. is now "Surgical Procedures" (changed from B. to C.). C.1. Will now be "Short limb Roux-en-Y" (moved from end to beginning of C.1); C.2. Will now be "Long limb Roux-en-Y" (moved from end to beginning of C.2); Deleted C.3.b. ~~BMI <50~~ (Patients with BMI >50 need a procedure to achieve greater weight loss. Thus the use of adjustable gastric banding, which results in less weight loss, should be most useful as one of the procedures used for patients with BMI <50.)

Section D. is now Surgical Revision (changed from C. to D. and deleted "~~Reoperation and~~"; D.2.o. Deleted "~~Disrupted staple line provided there has been prior weight loss~~". D.2.o. is now "*Intractable ulcer*".

"When Not Covered" section revisions:

2.d. Adjustable Gastric Banding: Deleted ~~d.ii. in patients with a BMI ≥50.~~ Added 2.k. "*Endoscopic procedures (e.g., insertion of the StomaphyX™ device) to treat weight gain after bariatric surgery to remedy large gastric stoma or large gastric pouches.*"

"Policy Guidelines" section revisions:

3 now reads "*Within 12 months prior to surgery, a thorough nutritional evaluation by a physician or registered dietician experienced in the issues of bariatric surgery, who has had a meaningful conversation with the individual regarding the dietary and lifestyle changes required to ensure a successful outcome over time.*"

#4 now reads "*Evaluation by a licensed psychologist or psychiatrist that documents the absence of significant psychopathology that can limit the patient's understanding of the procedure or the ability to comply with medical/surgical recommendations and to adhere to required lifestyle modifications and follow up/social support. Psychologist/Psychiatrist must document the patient's suitability for the proposed bariatric surgery and the lifetime commitment required for a successful outcome.*"

#5 now reads "*Appropriate* medical work up may include a chest x-ray, upper gastrointestinal series, *endoscopy*, appropriate pre-op labs and ECG. *A complete physical examination by the attending surgeon and an assessment of thyroid levels is required.* If the patient has comorbid conditions (e.g. diabetes or cardiovascular disease) the patient must be capable of undergoing the procedure.

Statement under #6 now reads "*The first five criteria must be met before seeking prior plan approval, the sixth must be met prior to surgery.*"

Other:

Description section revised. Medical term definitions and Reference sources added.

Notification given 10/6/08. Effective date 1/5/2009. (pmo)

- 3/2/09 A.2. under "When Covered" section revised as follows: "Morbid obesity (BMI ≥ 35 associated with at least one of the problems listed in A.1.b. or BMI ≥ 40) has been present for *at least the previous two* ~~four of the previous five~~ years;" (pmo)
- 1/5/10 Policy reformatted. CPT code 43775 effective January 1, 2010 added to Billing/Coding section. System Application Guidelines not updated due to conversion to the QMP real time database. (pmo)

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- 4/27/10 Description section updated to include information regarding endoluminal bariatric procedures. Revised criteria for Revision Bariatric Surgery in the When Covered section. In the When Not Section, statement regarding Sleeve Gastrectomy revised to read: [it is not covered] either as a stand-alone procedure or as the first step in a planned staged procedure for high-risk, super-obese patients. Also added the statement: Surgery for Morbid Obesity [is not covered] As a cure for type 2 diabetes mellitus. Added “licensed clinical social worker” to the Policy Guidelines section. Notification given 4/27/2010 for effective date 8/3/2010. (adn)
- 12/21/10 Specialty Matched Consultant Advisory Panel review meeting 11/29/10. Policy accepted as written. (adn)

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