MetroPlus Health

Policy and Procedure

Title: Bariatric Surgery	**Division: Medical Management** **Department: Utilization Management**
Approval Date: 7/20/17	**LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, GoldCare I&II, Market Plus, Essential, HARP**
Effective Date: 7/20/17	**Policy Number: UM-MP202**
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Retired Date:	**Page 1 of 9**

A. POLICY DESCRIPTION: This policy will outline the MetroPlusHealth medical necessity criteria for approval of bariatric surgical procedures.

B. RESPONSIBLE PARTIES: Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

C. DEFINITIONS:

1) **Bariatric surgical procedure types:** Restrictive, malabsorptive and combined, all of which may be performed using either the laparoscopic or open approach.
    i. 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 30mL or less and leaving only a small channel to the remaining stomach.
    ii. 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, including liver failure and electrolyte depletion.
    iii. 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.
2) **Body Mass Index (BMI):** A quantitative method of defining obesity in a ratio of weight to height (kg/m^2).
3) **Biliopancreatic Diversion with duodenal switch (BPD/DS):** A combined malabsorptive / restrictive procedure whereby a suprapapillary Roux-en-Y duodenojejunostomy 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.
4) **Laparoscopic adjustable gastric banding (LAGB):** The laparoscopic adjustable gastric banding procedure involves placing an inflatable silicone band around the upper portion of the stomach. The silicone band contains a saline reservoir that can be filled or emptied under the fluoroscopic guidance to change the caliber of the gastric opening.
5) **Roux-en-Y gastric bypass (RYGB):** 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.
6) **Sleeve gastrectomy:** 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.

7) **Vertical gastric banding (VGB) / vertical-banded gastroplasty (VBG) (vertical gastric stapling or partitioning):** 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.

D. POLICY:

1) Roux-en-Y Gastric Bypass (RYGB), Laparoscopic Adjustable Silicone Gastric Banding (LASGB), Sleeve Gastrectomy, Biliopancreatic Diversion (BPD) and Duodenal Switch (DS) procedures are considered medically necessary when ALL the criteria below are met:
   a) Adults aged 18 years or older:
      i) Presence of persistent severe obesity, documented in clinical records, defined as any of the following:
         (1) Body Mass Index (BMI) greater than 40 measured prior to the preoperative program OR
         (2) BMI greater than 35 measured prior to the preoperative program and any of the following severe co-morbidities exist:
            (a) History of coronary artery disease with surgical intervention such as coronary artery bypass or percutaneous transluminal coronary angioplasty
            (b) Coronary heart disease, with objective documentation (by exercise stress test, radionuclide stress test, pharmacologic stress test, stress echocardiography, CT angiography, coronary angiography, heart failure or prior myocardial infarction);
            (c) Obstructive Sleep Apnea (OSA) confirmed on polysomnography with an AHI or RDI of greater than or equal to 30 (Screening is not required for persons already diagnosed with OSA.)
            (d) Medically refractory hypertension (systolic blood pressure greater than 140 mmHG or diastolic blood pressure greater than 90 mmHG despite pharmacotherapy)
            (e) Type 2 Diabetes Mellitus
            (f) Non-alcoholic steatohepatitis (NASH)
   b) Adolescents who have completed bone growth (generally age 13 in girls and age 15 in boys) with:
      i) BMI greater than 40 with one or more of the following serious co-morbidities:
         (1) Obstructive Sleep Apnea (OSA) confirmed on polysomnography with an AHI or RDI of greater than or equal to 30 (Screening is not required for persons already diagnosed with OSA.)
         (2) Type 2 Diabetes Mellitus
         (3) Nonalcoholic steatohepatitis (NASH)
         (4) Pseudotumor comorbidities
      ii) BMI greater than 50 with one or more of the following less serious co-morbidities:
         (1) Medically refractory hypertension
         (2) Dyslipidemias
         (3) Nonalcoholic steatohepatitis (NASH)
         (4) Venous stasis disease

(5) Significant impairment in activities of daily living
(6) Intertriginous soft-tissue infections
(7) Stress urinary incontinence
(8) Gastroesophageal reflux disease
(9) Weight-related arthropathies that impair physical activity
(10) Obesity-related psychosocial distress

c) Member has attempted weight loss in the past without successful long-term weight reduction.
d) Active participation within the last 2 years in a physician-directed weight-management program for ≥ 6 months without significant gaps (or 3 months if provided through a multidisciplinary bariatric surgery program). The program must include monthly documentation of all the following components:
   (i) Vital signs including weight
   (ii) Current dietary program.
   (iii) Physical activity (i.e., exercise program)
   (iv) Behavioral interventions to reinforce healthy eating and exercise habits.
   (v) Consideration of pharmacotherapy with U.S. Food and Drug Administration (FDA)- approved weight-loss drugs, if appropriate
e) Screening for diabetes, with initiation of appropriate treatment for persons diagnosed with diabetes. Screening is not required if the member has already been diagnosed with diabetes.
f) Screening for Obstructive Sleep Apnea (OSA).using a validated screening questionnaire (including the ESS, STOP Questionnaire (Snoring, Tiredness, Observed Apnea, High Blood Pressure), STOP-Bang Questionnaire (STOP Questionnaire (Screening is not required for persons already diagnosed with OSA);
g) Cardiac clearance by a cardiologist for persons with a history of cardiac disease.
h) Optimized glycemic control or for persons with diabetes who are unable to achieve glycemic control there should be documentation of consultation with an endocrinologist or diabetologist prior to surgery.
i) Psychological clearance by a mental health professional. The mental health provider should complete a psychological evaluation and document that there are no identified behavioral health contraindications to the proposed surgery. In addition, has Bariatric Surgery been discussed with the member and they understand the risks and benefits of the surgery. The results of the evaluation should ensure that the treatment team has a better understanding of the members motivation, readiness, behavioral challenges, and emotional factors that may impact their coping and adjustment through surgery and the associated lifestyle changes.

2) Vertical Banded Gastroplasty (VBG) is considered medically necessary for members who meet the selection criteria for obesity surgery above and who are at increased risk of adverse consequences of a RYGB due to the presence of ANY of the following co-morbid medical conditions:
   a) Demonstrated complications from extensive adhesions involving the intestines from prior major abdominal surgery, multiple minor surgeries, or major trauma.
   b) Hepatic cirrhosis with elevated liver function tests.
   c) Inflammatory bowel disease (Crohn's disease or ulcerative colitis).

d) Poorly controlled systemic disease.
e) Radiation enteritis

3) Additional Procedures for Bariatric Surgery Complications are considered medically necessary when ANY of the following criteria are met:
   a) Removal of a gastric band is recommended by the member's physician.
   b) Surgery to correct complications from bariatric surgery is needed (e.g., obstruction, stricture, erosion, or band slippage).
   c) Surgery for Roux Syndrome (aka Candy Cane Syndrome) is needed in cases where the member is symptomatic (abdominal pain, nausea, emesis) and diagnosis is confirmed by endoscopy or upper gastrointestinal studies.
   d) Replacement of an adjustable band if there are complications (e.g., port leakage, slippage) and the correction cannot be made with band manipulation or adjustments.

4) Repeat Bariatric Procedures for members whose initial bariatric surgery was medically necessary are considered medically necessary when ANY of the following criteria are met:
   a) Conversion to a sleeve gastrectomy, RYGB, or BPD/DS for members who have not had loss of more than 50% of excess body weight 2 years following the primary bariatric surgery and the member has been compliant with a prescribed nutrition and exercise program following the procedure.
   b) Revision of primary bariatric surgery procedure that has failed due to dilation of the gastric pouch, dilated gastrojejunal stoma, or dilation of the gastrojejunostomy anastomosis when the primary procedure was successful in inducing weight loss prior to the complication, and the member has been compliant with a prescribed nutrition and exercise program following the procedure.
   c) Conversion from an adjustable band to a sleeve gastrectomy, RYGB or BPD/DS for members who have been compliant with a prescribed nutrition and exercise program following the band procedure, and there are complications that cannot be corrected with band manipulation, adjustments, or replacements.

5) Gastric Band Adjustments are considered medically necessary when ANY of the following criteria are met:
   a) Reduction of band volume in members who have difficulty swallowing, persistent reflux or heartburn, or nighttime coughing or regurgitation.
   b) Reduction of band volume in members with maladaptive eating habits such as eating only soft carbohydrate and fat laden food due to inability to tolerate any solid foods when the member has attempted to be compliant with dietary follow up and recommendations.
   c) Increase in band volume in members with increased hunger, increased portion sizes at approximately 6-week intervals until appropriate fill volume has been achieved. 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.

6) Cholecystectomy when performed in concert with elective bariatric procedures are considered medically necessary due to a documented high incidence of gallbladder disease in post bariatric surgery patients.

7) Liver biopsy during an elective bariatric surgery is considered medically necessary when there are signs and symptoms of liver disease such as elevated liver enzymes or an enlarged liver.

E. LIMITATIONS/EXCLUSIONS

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).

F. APPLICABLE PROCEDURE CODES:

CPT	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
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum

43659	Unlisted laparoscopy procedure, stomach
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) new code effective date 01/01/2010
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
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
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
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
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open
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
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
0312T	Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation
0313T	Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator

0314T	Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator
0315T	Vagus nerve blocking therapy (morbid obesity); removal of pulse generator
0316T	Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator
0317T	Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed

G. REFERENCES:

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H. RELATED MEDICAL POLICIES:

Policy Number	Policy Name
UM-MP200	Abdominoplasty, Panniculectomy
UM-MP239	Sleep Study

I. REVISION LOG:

REVISIONS	DATE
Creation date	7/20/2017
Annual Review	10/25/19
Annual Review	10/2/20
Annual Review	9/1/21
Annual Review	8/29/22
Annual Review	5/30/2023
Medicare and UltraCare LOB's were removed from header	8/7/2023
Annual Review. References updated	4/23/24

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Approved:

Sanjiv Shah, MD
Chief Medical Officer

Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan 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). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program 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 MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government, or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication. MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.