Clinical Policy: Bariatric Surgery
Reference Number: MI.CP.MP.37
Last Review Date: 05/24

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.

Medically indicated weight loss surgery is a covered service for the treatment of obesity when medically indicated and when the procedure performed is within professional standards of medical practice. Covered surgical procedures may include, **but are not limited** to, gastric bypass, gastric band, sleeve gastrectomy, removal, revision, and/or replacement of adjustable gastric restrictive devices, and subcutaneous port components and repeat procedures.

Definition

Body mass index (BMI)	A measure of body fat based on height and weight that applies to adult men and women. The World Health Organization defines the terms overweight and obesity based on BMI thresholds. In its consensus panel statement of 1991, the NIH stated that the "risk for morbidity linked with obesity is proportional to the degree of overweight." However, BMI does not account for an individual's sex, age, ethnicity, or fat distribution, and is recognized as only an approximation of adiposity. The health risk in a patient with BMI 30 kg/m2 with visceral and ectopic fat accumulation and subsequent metabolic and cardiovascular disease would be significantly higher than a patient with BMI 40 kg/m2 whose adipose tissue is mainly accumulated in the lower extremity. In the Asian population the prevalence of diabetes and cardiovascular disease is higher at a lower BMI than in the non-Asian population. Thus, BMI risk zones should be adjusted to define obesity at a BMI threshold of 25–27.5 kg/m2 in this population. Therefore, in certain populations access to MBS should not be denied solely based on traditional BMI thresholds.

Policy/Criteria

I. It is the policy of MeridianHealth that bariatric surgery is **medically necessary** when the below criteria **are met in A. (1, 2, or 3 and 4):**
   A. Age and body mass index (BMI):
      1. **Age ≥ 18 and one of the following (a or b):**
         a. BMI ≥ 35 kg/m² regardless of the presence or absence of co-morbidities; ***or***

b. BMI ≥ 30 kg/m^2 and < 35 kg/m² and at least one of the following co-morbid conditions:
   i. Type 2 Diabetes
   ii. High risk for type 2 DM (insulin resistance, prediabetes, and/or metabolic syndrome);
   iii. Hypertension;
   iv. Dyslipidemia;
   v. Obstructive sleep apnea;
   vi. Obesity-hypoventilation syndrome/Pickwickian syndrome;
   vii. Nonalcoholic fatty liver disease or nonalcoholic steatohepatitis;
   viii. Pseudotumor cerebri;
   ix. Coronary artery disease;
   x. Gastroesophageal reflux disease;
   xi. Asthma;
   xii. Venous stasis disease;
   xiii. Bone and joint disease;
   xiv. ;
   xv. Disqualification from other specialty surgeries due to obesity (i.e., joint arthroplasty,
   xvi. Chronic kidney disease
   xvii. Polycystic ovarian disease
   xviii. abdominal wall hernia repair, or organ transplantation;

2. **Age ≥ 18 with excess abdominal obesity if medically indicated (a or b):**
   a. BMI ≥ 32.5 kg/m^2 and ≤34.9 kg/m^2 regardless of the presence or absence of co-morbidities; ***or***
   b. BMI ≥ 27.5 and ≤32.4 kg/m^2 and at least one of the following co-morbid conditions:
      i. Type 2 Diabetes;
      ii. High risk for type 2 DM (insulin resistance, prediabetes, and/or metabolic syndrome);
      iii. Poorly controlled Hypertension;
      iv. Dyslipidemia;
      v. Obstructive sleep apnea;
      vi. Obesity-hypoventilation syndrome/Pickwickian syndrome;
      vii. Nonalcoholic fatty liver disease or nonalcoholic steatohepatitis;
      viii. Pseudotumor cerebri;
      ix. Coronary artery disease;
      x. Gastroesophageal reflux disease;
      xi. Asthma;
      xii. Venous stasis disease;
      xiii. Bone and joint disease;
      xiv. Disqualification from other specialty surgeries due to obesity (i.e., joint arthroplasty, abdominal wall hernia repair, or organ transplantation).
      xv. Chronic kidney disease
      xvi. Polycystic ovarian disease

3. **Age < 18 years, LSG or laparoscopic RYGB is requested, and one of the following (a or b):**
   a. BMI ≥ 40 kg/m² or 140% of the 95th percentile (whichever is lower); ***or***
   b. BMI ≥ 35 kg/m² and ≤39.9 or 120% of the 95th percentile (whichever is lower) with ≥ 1 severe comorbidity listed below that has significant

short-term effects on health and that is uncontrolled with lifestyle or pharmacotherapy management:

i. Type 2 DM
ii. Obstructive sleep apnea;
iii. Idiopathic intracranial hypertension;
iv. Nonalcoholic fatty liver disease or nonalcoholic steatohepatitis;
v. Blount's disease;
vi. Slipped capital femoral epiphysis (SCFE);
vii. Gastroesophageal reflux disease;
viii. Hypertension;
ix. Hyperlipidemia;
x. Insulin resistance

II. The following bariatric surgical 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.

III. Medical literature is inadequate to determine the safety, efficacy, and long-term outcomes for the following bariatric surgical procedures and are therefore deemed **not medically necessary**:

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 intragastric balloon, Obalon Balloon).

IV. Procedures considered investigational/experimental are **not covered services**.

V. Coverage of **associated medically necessary reconstructive procedures** directly attributable to weight loss surgery, such as panniculectomy procedures, will be considered through the prior authorization (PA) process. Providers must obtain a separate PA for these services.

VI. Removal, revision, and/or replacement of adjustable gastric restrictive devices, and subcutaneous port components and repeat procedures are reviewed with InterQual® criteria.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for 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

CPT®* Codes	Description
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)
43632	Gastrectomy, partial, distal; with gastrojejunostomy
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
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed and original approval date		7/28/23
Revised: health behavior/psychosocial assessment criteria removed	8/24/2023	8/24/2023
Revisions: **Comorbid conditions for over 18yo:** removed "poorly controlled" hypertension to hypertension, removed severe urinary incontinence, removed osteoarthritis to bone and joint disease, removed idiopathic intracranial hypertension, added chronic kidney disease, added polycystic ovarian disease. **Comorbid conditions for <18yo:** added nonalcoholic fatty liver disease	05/07/24	06/28/24

Line of Business Applicability:
This policy applies to Michigan Medicaid
Coverage is based on medical necessity criteria being met and the codes being submitted and considered for review being included on the Michigan Medicaid Fee Schedule (located at: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-159815--,00.html)
If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual (located at: https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-87572--,00.html), the applicable Medicaid Provider Manual will govern.

References

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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.

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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.

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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.