Medical Affairs Policy

**Service:** Bariatric Surgery  
*PUM 250-0009*

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<th>Medical Policy Committee Approval</th>
<th>03/17/17</th>
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<td>Effective Date</td>
<td>07/01/17</td>
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<td>Prior Authorization Needed</td>
<td>Yes</td>
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**Note:** Many member health plans have a specific exclusion for bariatric surgery.

**Disclaimer:** This policy is for informational purposes only and does not constitute medical advice, plan authorization, an explanation of benefits, or a guarantee of payment. Benefit plans vary in coverage and some plans may not provide coverage for all services listed in this policy. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Some benefit plans administered by the organization may not utilize Medical Affairs medical policy in all their coverage determinations. Contact customer services as listed on the member card for specific plan, benefit, and network status information.

Medical policies are based on constantly changing medical science and are reviewed annually and subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG to assist in administering health benefits. This medical policy and MCG guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider. To obtain additional information about MCG, email medical.policies@wpsic.com.

**Description:**

There is scientific evidence that bariatric surgery can be safe and effective in allowing individuals with severe obesity to lose substantial weight and improve their weight-related comorbidities, provided those patients are appropriately selected and participate in a comprehensive weight management program which includes appropriate medical, nutritional, and psychological care.

Traditionally bariatric procedures have been classified as restrictive, malabsorptive, or both. Restrictive procedures (lap band, sleeve gastrectomy, vertical sleeve gastrectomy) reduce the volume of the stomach. Malabsorptive procedures (Roux-en-Y, gastric bypass, biliopancreatic diversion [BPD]) divert the flow of the nutrients/food and reduce the absorptive surface of the GI tract. These GI procedures cause weight loss by mechanisms involving complex neurohormonal pathways. “Metabolic surgery” (manipulation of a normal organ or organ system to achieve a metabolic goal) alters the gut-brain-adipose communication, potentially resulting in significant and sustainable weight reduction, improvement/remission of diabetes, obstructive sleep apnea, hypertension, dyslipidemia, and decreased mortality.

**Indications of Coverage:**

I. Gastric bypass, laparoscopic adjustable gastric banding, laparoscopic or open Roux-en-Y, biliopancreatic diversion (BPD), and Laparoscopic sleeve
gastrectomy are considered medically necessary when all the following criteria are met:

A. Age 18 and over, with a body mass index (BMI) greater than 40

OR

Age 18 and over, with a BMI greater than 35 with one of the following comorbid conditions:

1. Coronary artery disease with evidence of previous CABG or PCI (percutaneous coronary intervention), or obesity-related cardiomyopathy

2. Diabetes Mellitus

3. Hypertension: difficult to control (defined as hypertensive despite a maximum dose of 3 antihypertensive agents) while compliant with medical therapy

4. Sleep apnea that requires Positive Airway Pressure (PAP) treatment (e.g. Obstructive Sleep Apnea or Obesity Hypoventilation Syndrome diagnosed by a sleep medicine specialist)

5. Pseudotumor cerebri

6. Degenerative joint disease with prior total joint arthroplasty or documentation of need for joint replacement

7. Metabolic syndrome

8. Gastro-Esophageal Reflux Disease (GERD)

B. Documentation of complete history and physical (including evaluation and treatment of obesity related comorbidities, BMI history, history of previous weight loss attempts, and evaluation of surgical risks. Cardiac, pulmonary, endocrine, and GI evaluation is obtained as indicated.

➢ Note: For a member with COPD, documentation includes surgery recommended in consultation with the member’s treating pulmonologist.

C. Nutritional evaluation: (by a Registered Dietician) that includes all the following:

1. Minimum of three visits within the past 12 months
2. Initial clinical nutrition evaluation (may include micronutrients)

3. Instruction for post-surgery diet

4. Documentation that there is a reasonable expectation based on the evaluation and adherence to the pre-surgical program, that the member will be able to comply with the post-surgical diet plan.

D. Documentation of a psychological evaluation that assesses appropriateness for surgery, issues related to addiction, and ability to comply with the pre-and postoperative program. If the member is receiving treatment for an active behavioral health disorder, clearance from the treating provider is required with documentation that the patient’s psychiatric illness has been optimally treated.

E. Documentation that, within the past 12 months, there has been at least six months (three consecutive) of participation in a professionally supervised multidisciplinary weight loss program. Documentation must consist of actual progress notes for the dates of participation in the program. This documentation must include weight data as well as documentation that diet, exercise, and behavior modification were addressed. Participation which is summarized in the form of a letter is not acceptable. Appropriate documentation is:

1. Dated progress notes from one of the professionals (physician, dietician, or weight-loss professional) supervising diet, exercise, and behavior modification at least once every four to eight weeks during the six-month period with clear evidence that weight reduction management was the primary service provided to the patient on that date.

F. Surgery must be performed by a credentialed bariatric surgeon.

➢ Note: Repeat bariatric surgery requires physician review (when it is not an exclusion of the policy or health plan).

II. Bariatric surgery on an individual under 18 years of age requires physician review. Services must be performed in a pediatric bariatric surgery center of excellence that provides the necessary infrastructure for patient care, including a team capable of long-term follow-up of the metabolic and psychosocial needs of the patient and family, and treatment must be consistent with the recommendations in the Endocrine Society Clinical Practice Guideline published in the Journal of Clinical Endocrinology and Metabolism available at click here.
Limitations of Coverage:

A. Review contract and endorsements for exclusions and prior authorization or benefit requirements.

B. If used for a condition/diagnosis other than is listed in the Indications of Coverage, deny as experimental, investigational, and unproven to affect health outcomes.

C. If used for a condition/diagnosis that is listed in the Indications of Coverage but the criteria are not met, deny as not medically necessary.

D. Bariatric surgery for the management and treatment of GERD, gallbladder disease, or diabetes, osteoarthritis, gallstones, urinary stress incontinence, or gastroparesis without meeting all the above criteria, is considered experimental or investigational as there is insufficient peer-reviewed medical literature documenting the effectiveness of these procedures for the management of these conditions.

E. Bariatric surgery for treatment of non-alcoholic steatohepatitis with advanced fibrosis, Non-alcoholic fatty liver disease (NAFLD), and non-alcoholic steatohepatitis (NASH) with or without meeting all the above criteria, is considered experimental, investigational, and unproven to affect health outcomes. Results regarding postoperative outcomes are conflicting.

F. Routine cholecystectomy (removal of the gallbladder) at the time of bariatric surgery, without documentation of preoperative identification of gallbladder disease is considered incidental to the bariatric surgery.

G. The following bariatric procedures are considered experimental or investigational as there is insufficient peer-reviewed medical literature documenting the effectiveness of these procedures over standard bariatric procedures:

1. Intragastric balloon (e.g. Orbera Intragastric Balloon System, Reshape Integrated Dual Balloon System)

2. Gastric plication

3. Electrical neuromodulation, Gastric electrical stimulation with an implantable gastric stimulator (IGS)

4. Vagal blockade / Vagus Nerve Blocking (VNB) (e.g. Maestro Rechargeable System)

5. Endoluminal vertical gastroplasty
6. Implantable gastric pacing

7. Endoscopic gastrointestinal bypass device

8. Mini-gastric bypass or Laparoscopic Mini-gastric bypass


10. Transoral Endoscopic Surgery

11. Restorative Obesity Surgery, endoluminal (ROSE) procedure

12. Aspire Assist (Aspiration Therapy) device

13. Vertical Banded Gastroplasty

**H.** Bariatric surgery is considered not medically necessary if any of the following conditions are documented:

1. Current drug abuse/alcohol abuse within the last three months

2. Terminal disease

3. Chronic obstructive pulmonary disease unless surgery is recommended in consultation with the member’s treating pulmonologist

4. Active untreated eating disorder or untreated psychiatric disorder

5. Cognitive impairment that would interfere with patient’s ability to comply with the post-operative treatment plan

**Documentation Required:**

- Office notes
- Psychological evaluation report
- X-rays (if applicable)
References:


31. MCG Inpatient & Surgical Care 18th Edition ORG: S-512 (ISC) Gastric Restrictive Procedure with Gastric Bypass


42. UpToDate. Electrical stimulation for gastroparesis. Literature review current through: Jan 2017. This topic last updated: Sep 16, 2015.

43. MCG 21st ed. ISC S-512 Gastric Restrictive Procedure with Gastric Bypass
44. MCG 21st ed. ISC S-513 Gastric Restrictive Procedure with Gastric Bypass by Laparoscopy

45. MCG 21st ed. ISC S-515 Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy

46. MCG 21st ed. ISC S-512 Gastric Restrictive Procedure with Gastric Bypass

47. MCG 21st ed. ACG: A-0395 Gastric stimulation (electrical)


50. Hayes MTD Laparoscopic Sleeve Gastrectomy for Super Obesity in Adults Annual Review sept 15, 2016 Publication Date October 19, 2012


52. Hayes HTB. Maestro Rechargeable System for Vagal Blocking for Obesity Control (VBLOC) February 4, 2016


WPS / Arise Review History:

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➢ Note: For review/revision history prior to 2014 see previous Medical Policy or Coverage Policy Bulletin

Approved by the Medical Director