

Corporate Medical Policy

Surgery for Morbid Obesity

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Description of Procedure or Service

Morbid obesity is a condition of persistent and uncontrollable weight gain that is a potential threat to life. It 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, and has a prevalence in the United States of 6% for women and 2% for men. 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.

There are a variety of surgeries intended to treat morbid obesity (termed bariatric surgery). All of the surgeries are based on one of two premises:

- ◆ Alteration in the volume of food eaten ([Gastric](#) restrictive procedures)
- ◆ Alteration of food absorption (Malabsorptive procedures)

Some bariatric surgeries may include both a restrictive and a malabsorptive component. 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 2 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 – [laparoscopy](#), surgical, [gastric](#) restrictive procedure; placement of adjustable [gastric](#) restrictive device [e.g., [gastric](#) band and subcutaneous port components]) 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. 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. Currently there are two devices approved for marketing by the U.S. Food and Drug Administration (FDA); the Lap-Band

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(BioEnterics, Carpentiera, CA) and REALIZE model (Ethicon Endo-Surgery, Cincinnati, OH). The labeled indications for these devices 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 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."

"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—**gastric** restrictive procedure, with **gastric** bypass for morbid obesity; with short limb [150 cm or less] Roux-en-Y gastroenterostomy) 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—**laparoscopy**, surgical, **gastric** restrictive procedure; with **gastric** bypass and Roux-en-Y gastroenterostomy [**roux limb** 150 cm or less]) 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** (no specific CPT code). 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 tran-

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sit 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.

Malabsorptive Procedures

There are multiple variants of malabsorptive procedures, which 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- [gastric](#) restrictive procedure, with [gastric](#) bypass for morbid obesity; with small intestine reconstruction to limit absorption) 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.

- a. 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.
- b. A 200-cm long "[alimentary](#) tract" consists of 200 cm of [ileum](#) connecting the stomach to a common distal segment.
- c. A 300- to 400-cm "biliary tract," which connects the [duodenum](#), [jejunum](#), and remaining [ileum](#) to the common distal segment.
- d. 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.
- e. 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 - [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]) 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 stom-

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ach 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—[Gastric](#) restrictive procedure with [gastric](#) bypass for morbid obesity; with small intestine reconstruction to limit absorption) Recently, variations of [gastric](#) bypass procedures have been described, consisting primarily of long-limb Roux-en-Y procedures, which vary in 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—[Laparoscopy](#), surgical, [gastric](#) restrictive procedure; with [gastric](#) bypass and small intestine reconstruction to limit absorption) 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

Please refer to certificate for availability of benefit. This policy relates only to the services or supplies described herein. Benefits may vary according to benefit design, therefore certificate language should be reviewed before applying the terms of the policy.

When Surgery for Morbid Obesity is covered

- A. **Criteria for Adults** - Surgery for Morbid Obesity is covered when **all five** of the following criteria are met:
1. The patient must have morbid obesity as defined below:
 - a. have a **BMI** \geq 40 (Refer to **BMI** table on pages 13 and 14) **or**
 - b. 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:

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- i. 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**
 - 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; **or**
 - iii. There is significant respiratory insufficiency as evidenced by $p\text{CO}_2 > 50$ mmHg, hypoxemia at rest, as evidenced by $p\text{O}_2 < 55$ mmHg on room air; **FEV1/FVC** $< 65\%$, or DLCO $< 60\%$ (e.g., **Obesity Hypoventilation Syndrome**); **or**
 - 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); **or**
 - v. Type 2 diabetes mellitus; **or**
 - vi. Documented coronary artery disease; **or**
 - vii. Cardiomyopathy; **or**
 - viii. Heart failure; **or**
 - ix. Gastroesophageal reflux disease with secondary asthma or erosive esophagitis not controlled despite maximum dosages of proton pump inhibitors; **or**
 - x. Pseudotumor cerebri; **or**
 - 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; **AND**
 2. 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**
 3. The patient has no specifically correctable cause for the obesity, e.g., an endocrine disorder; **AND**
 4. 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**
 5. 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**).
- B. **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.
- C. **Surgical Procedures** - The following surgical procedures are considered eligible for coverage for the morbidly obese individual **who meets the preceding criteria**:

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1. **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](#).
 2. **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).
 3. **Adjustable Gastric Banding** - Additional criteria include the following:
 - a. 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.
 4. **Biliopancreatic bypass with or without duodenal switch** may be considered on an individual consideration basis for patients with a [BMI](#)>50.
- D. **Surgical Revision**-The following may be considered medically necessary for patients whose initial surgery met medical necessity criteria:
1. Surgical reversal (i.e., takedown) when the patient develops complications from the original surgery such as stricture (narrowing) or obstruction.
 2. The following are examples of conditions and/or diagnoses for which revisions to the primary surgical procedure for morbid obesity may be covered:
 - a. Weight loss of 20% or more below the ideal body weight;
 - b. Esophagitis (e.g., esophageal reflux);
 - c. Hemorrhage or hematoma complicating a procedure;
 - d. Vomiting (bilious) following gastrointestinal surgery;
 - e. Gastrointestinal complications, (i.e., complications of intestinal (internal) [anastomosis](#) and bypass);
 - f. Stomal [dilation](#), documented by endoscopy;
 - g. [Pouch dilation](#) documented by upper gastrointestinal examination or endoscopy, producing weight gain of 20% or more provided that the primary procedure was successful in inducing weight loss prior to the [pouch dilation](#), **and** the patient has been compliant with a prescribed nutrition and exercise program following the procedure (compliance with diet and exercise must be documented via a detailed evaluation by a mental health provider and/or nutritionist);
 - h. Stomal stenosis after vertical banding, documented by endoscopy, producing vomiting or weight loss of 20% or more;
 - i. Other and unspecified post surgical nonabsorption (i.e., hypoglycemia and malnutrition following gastrointestinal surgery);
 - j. Other post-operative functional disorders (i.e., diarrhea following gastrointestinal surgery);
 - k. Severe dumping syndrome;
 - l. Post-[gastric](#) surgery syndromes (i.e., post-gastrectomy syndrome, post-vagotomy syndrome);
 - m. Disruption of operative wound;
 - n. Staple line failure, documented by upper gastrointestinal examination;
 - o. Intractable ulcer.

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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. Jejunioleal 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:
 - i. 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 the sole procedure or as one step in a staged procedure.
 - g. **Gastric** bypass using a Billroth II type of **anastomosis**, popularized as the **mini-gastric bypass**.
 - h. **Gastric** electrical stimulation. (Refer to separate policy number SUR6353 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) to treat weight gain after bariatric surgery to remedy large **gastric stoma** or large **gastric** pouches.
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

Surgery for Morbid Obesity may require Prior Plan Approval.

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.

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4) 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) 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, 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 number SUR6170, 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.bcbsnc.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.

Medical Term Definitions

Alimentary

pertaining to food or nutritive material, or to the organs of digestion.

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Anastomosis

the surgical connection of two hollow structures (e.g., stomach to intestine, intestine to intestine, intestine to colon, bile duct to intestine). The structures can be connected end to end, end to side, or side to end. The connection can be accomplished by use of sutures, surgical staples, or a combination of both.

Antrum

the pyloric end of the stomach, partially shut off during digestion from the cardiac end by sphincter muscles in the stomach wall.

Biliopancreatic limb

the segment of small bowel connecting the bile duct to the distal end of the Roux limb. This segment follows the Roux limb and is the bile-carrying limb.

Body Mass Index

a measure of the body fat that is the ratio of the weight of the body in kilograms to the square of its height in meters. A body mass index that exceeds a value of 28 for a man or 27 for a woman is often used as an indication of obesity. Also referred to as BMI. $BMI = \text{weight (kilograms)} / [\text{height (meters)}]^2$

Cholecystectomy

surgical excision of the gallbladder.

Cholelithiasis

production of gallstones; also: the resulting abnormal condition.

Comorbid

existing simultaneously with and usually independently of another medical condition

Dilation

the act of expanding or the condition of being expanded.

Duodenum

the first part of the small intestine; extends from the pylorus to the jejunum.

FEV1/FVC

the percentage of the vital capacity which is expired in the first second of maximal expiration. In healthy patients the FEV1/FVC is usually around 70%. In patients with obstructive lung disease FEV1/FVC decreases and can be as low as 20-30% in severe obstructive airway disease. Restrictive disorders have a near normal FEV1/FVC.

Gastric

pertains to the stomach.

Ileum

the distal portion of the small intestine.

Jejunum

the portion of the small intestine that extends from the beginning (duodenum) to the distal part (ileum).

Laparoscopy

examination of the abdominal cavity or performance of minor abdominal surgery using a laparoscope.

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Metabolic syndrome

a set of risk factors involving three or more of the following:

1. Elevated waist circumference [Men - equal to or greater than 40 inches (102 cm); Women - equal to or greater than 35 inches (88 cm)]
2. Elevated triglycerides equal to or greater than 150 mg/dL or drug treatment for elevated triglycerides.
3. Reduced HDL (“good”) cholesterol: [Men - Less than 40 mg/dL; Women - Less than 50 mg/dL] or drug treatment for reduced HDL.
4. Elevated blood pressure equal to or greater than 130/85 or drug treatment for hypertension.
5. Elevated fasting glucose equal to or greater than 100 mg/dL or drug treatment for elevated glucose.

Obesity hypoventilation syndrome

the central features of OHS, as currently accepted, include obesity (BMI > 30 kg/m²), chronic alveolar hypoventilation leading to daytime hypercapnia and hypoxia (PaCO₂ > 45 mm Hg and PaO₂ < 70 mm Hg), and sleep-disordered breathing. Essential to the diagnosis is exclusion of other causes of alveolar hypoventilation such as severe obstructive or restrictive pulmonary disease, significant kyphoscoliosis, severe hypothyroidism, neuromuscular diseases, or other central hypoventilation syndromes. Although OHS can exist autonomously, it is frequently associated with obstructive sleep apnea (OSA), which is characterized by recurrent upper airway obstruction resulting in apneas, hypopneas, oxygen desaturation, and arousals from sleep. In approximately 90% of patients with OHS the sleep-disordered breathing consists of OSA. The remaining 10% of patients with OHS have an apnea-hypopnea index less than 5. The sleep-disordered breathing in this subset of patients has been labeled as sleep hypoventilation and is defined as an increase in PaCO₂ during sleep by 10 mm Hg above wakefulness or significant oxygen desaturation that is not explained by obstructive apneas or hypopneas. Obesity hypoventilation syndrome is also known as the Pickwickian Syndrome

Panniculectomy

surgical excision of the abdominal apron of superficial fat in an obese patient.

Pouch

a surgically created portion of the stomach that serves as a reservoir for food immediately after food exits the esophagus.

Pyloric sphincter

A ring of smooth muscle fibers around the opening of the stomach into the duodenum.

Roux limb

the segment of small bowel where food exits the stomach and enters the bowel. The Roux limb starts where food enters and ends where the biliopancreatic limb joins it to form the common channel.

Stoma

an artificial opening between two hollow organs or between one hollow organ and the outside of the body, constructed to permit the passage of body fluids or waste products.

Scientific Background and Reference Sources

Committee on Blue Shield, March 1983

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

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Bariatric Physician Advisory Panel - 7/17/08

Specialty Matched Consultant Advisory Panel - 9/4/08

Bariatric Physician Advisory Panel - 1/7/09

Policy: Surgery for Morbid Obesity

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.
- 4/99 Policy updated with Milliman & Roberston 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 \geq 40; A.1.b - Statement revised to "have a BMI \geq 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 \geq 35 associated with at least one of the problems listed in A.1.b. or BMI \geq 40) has been present for four of the

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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 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 \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*: 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*

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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) \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; Metabolic syndrome; Pulmonary hypertension. A.4. has been deleted
~~"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 \geq 50.~~ Added 2.k. "Endoscopic procedures (e.g., insertion of the StomaphyXTM 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)

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- 3/2/09 A.2. under "When Covered" section revised as follows: "Morbid obesity (BMI \geq 35 associated with at least one of the problems listed in A.1.b. or BMI \geq 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)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.

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To use the table, find the appropriate height in the left hand column. Move across to a given weight. The number at the top of the column is the BMI of that height and weight. Pounds have been rounded off.

BODY MASS INDEX																	
	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
Height (inches)	Body Weight (pounds)																
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287

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BODY MASS INDEX																			
	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)	Body Weight (pounds)																		
58	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

To use the table, find the appropriate height in the left-hand column. Move across to a given weight. The number at the top of the column is the BMI at that height and weight. Pounds have been rounded off.⁷⁸

Table and calculations adapted from the National Heart, Blood and Lung Institute, available at http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm. Retrieved on 5/5/2003.