

**Coverage Policy Manual**

Policy #: 2023001

Category: Surgery

Initiated: January 2023

Last

January 2023

Review:

**Bariatric Surgery for ASE/PSE Contracts**

**Description:** Bariatric surgery is a treatment for morbid obesity in patients who fail to lose weight with conservative measures. There are numerous gastric and intestinal surgical techniques available. While these techniques have heterogeneous mechanisms of action, the result is a smaller gastric pouch that leads to restricted eating. However, these surgeries may lead to malabsorption of nutrients or eventually to metabolic changes.

Bariatric surgery is performed for the treatment of morbid (clinically severe) obesity. Morbid obesity is defined as a body mass index (BMI) greater than 40 kg/m<sup>2</sup> or a BMI greater than 35 kg/m<sup>2</sup> with associated complications including, but not limited to, type 2 diabetes, uncontrolled hypertension, cardiopulmonary conditions, severe obstructive sleep apnea, and other potentially life-threatening comorbid conditions (e.g. Pickwickian syndrome, pulmonary hypertension, etc) . Morbid obesity results in a very high risk for weight-related complications and a shortened life span. A morbidly obese man at age 20 can expect to live 13 years less than his counterpart with a normal BMI, which equates to a 22% reduction in life expectancy.

The first treatment of morbid obesity is dietary and lifestyle changes. Although this strategy may be effective in some patients, only a few morbidly obese individuals can reduce and control weight through diet and exercise. The majority of patients find it difficult to comply with these lifestyle modifications on a long-term basis.

When conservative measures fail, some patients may consider surgical approaches. A 1991 National Institutes of Health (NIH) Consensus Conference defined surgical candidates as those patients with a BMI\* of greater than 40 kg/m<sup>2</sup>, or greater than 35 kg/m<sup>2</sup> in conjunction with severe comorbidities such as cardiopulmonary complications or severe diabetes. (\*See Policy Guidelines on how to calculate BMI.)

Resolution (cure) or improvement of type 2 diabetes mellitus after bariatric surgery and observations that glycemic control may improve immediately after surgery, before a significant amount of weight is lost, have promoted interest in a surgical approach to treatment of type 2 diabetes. The various surgical procedures have different effects, and gastrointestinal rearrangement seems to confer additional anti-diabetic benefits independent of weight loss and caloric restriction. The precise mechanisms are not clear, and multiple mechanisms may be involved. Gastrointestinal peptides, glucagon-like peptide-1 (1GLP-1), glucose -dependent insulinotropic peptide (GIP), and peptide YY (PYY) are secreted in response to contact with unabsorbed nutrients and by vagally mediated parasympathetic neural mechanisms. GLP-1 is secreted by the L cells of the distal ileum in response to ingested nutrients and acts on pancreatic islets to augment glucose-dependent insulin secretion. It also slows gastric emptying, which delays digestion, blunts postprandial glycemia, and acts on the central nervous system to induce satiety and decrease food intake. Other effects may improve insulin sensitivity. GIP acts on pancreatic beta cells to increase insulin secretion through the same mechanisms as GLP-1, although it is less potent. PYY is also secreted by the L cells of the distal intestine and increases satiety and delays gastric emptying.

**Policy/Coverage:** *Note: Beginning January 1, 2023, for bariatric services for ASE/PSE members, please see the member's Summary Plan Description (SPD). This policy applies only to those contracts subject to Arkansas Act 109 for State and Public School Health Insurance program*

*Prior Authorization is required for all procedures described as covered under the above Act.*

*Coverage will be limited to surgeries performed at bariatric surgery centers which are accredited through the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program as determined by the American College of Surgeons and the American Society for Metabolic and Bariatric Surgery. Bariatric Surgery coverage shall be limited to one bariatric surgery per lifetime and one revision surgery in the case of surgical complications resulting directly from the bariatric surgery. If an Active Employee or Retiree under the age of 65 has previously had bariatric surgery on a different health insurance plan, they shall not be eligible for the Bariatric Surgery Benefit*

**Effective January 1, 2023****Medical Necessity**

1. Gastric bypass and gastric restrictive procedures are considered medically necessary when all the following criteria are met:

1. Individual is an active or retired state or public-school employee
2. Individual is age 20-65 years of age
3. Individual has at least five (5) years or greater of continuous employment as a state or public-school employee
4. Individual has not undergone previous bariatric surgery procedure

5. Individual presently meets one of the following:
  1. BMI is equal to or greater than forty kilograms per meter squared (40 kg/m<sup>2</sup>), OR
  2. BMI is equal to or greater than thirty-five kilograms per meter squared (35 kg/m<sup>2</sup>) with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes.
6. The recommended surgery is one of the following procedures:
  1. Gastric bypass surgery (Roux-en-Y procedure)
  2. Adjustable gastric banding surgery
  3. Sleeve gastrectomy
  4. Duodenal switch biliopancreatic diversion

## 2. Revision Surgery

1. Second bariatric surgery procedures, whether as a result of a prior surgery performed under the approval of the Plan or procured otherwise, are NOT covered services.
2. Revision surgery as second surgeries or surgical interventions meeting medical necessity to manage a complication of a prior bariatric surgery procedure that was performed under the approval of the Plan are covered services. [e.g., this second surgery may require an intervention that is also performed for bariatric purposes such as to treat refractory Gastro Esophageal Reflux Disease following a sleeve bariatric procedure, a Roux-en-Y may be undertaken).
3. The complication must be from one of the above covered primary procedures. Complications of prior non-covered procedures are not covered under the revision surgery benefit

### **Does Not Meet Medical Necessity Or Is Investigational**

The following procedures do not meet member benefit certificate medical necessity that there be scientific evidence of effectiveness in improving health outcomes:

- o Small bowel bypass procedures as stand-alone procedures
- o Gastric wrapping
- o The Garren-Edwards gastric bubble or any similar device
- o Mini gastric bypass (one anastomosis gastric bypass)
- o Jejunioleal bypass
- o Biliopancreatic bypass without duodenal switch
- o Endoscopic procedures (e.g., insertion of the StomaphyX<sup>®</sup> device, AspireAssist, insertion of a gastric balloon, including but not limited to the Obalon Balloon System, Orbera Intragastric Balloon System or the Transpyloric Shuttle, endoscopic gastroplasty, or use of an endoscopically placed duodenal-jejunal sleeve) to treat weight gain after bariatric surgery to remedy large gastric stoma or large gastric pouches, as primary surgical treatment for morbid obesity, or to repair gastric leaks
- o Long-limb gastric bypass (greater than 150cm)
- o Repair of a hiatal hernia that is diagnosed at the time of bariatric surgery, or repair of preoperatively diagnosed hiatal hernia in patients who do not have indications for surgical repair (Effective November 2014)
- o Laparoscopic gastric plication (Effective November 2014)
- o Vagus (or vagal) nerve blocking devices
- o Single anastomosis duodenoileal bypass with sleeve gastrectomy (Effective March 2016)
- o All other bariatric procedures not listed as covered

### **Policy Guidelines:**

#### **Patient Selection Criteria**

Morbid obesity is defined as a body mass index (BMI) 40 kg/m<sup>2</sup> or more or a BMI 35 kg/m<sup>2</sup> or more with at least 1 clinically significant obesity-related disease such as diabetes, obstructive sleep apnea, coronary artery disease, or hypertension for which these complications or diseases are not controlled by best practice medical management.

While there are limited evidence on which to assess the long-term impacts of bariatric surgery for patients younger than age 18 years, severely obese (BMI  $\geq$ 40 kg/m<sup>2</sup> or 140% of the 95th percentile for age and sex, whichever is lower) adolescents with commonly present though not required comorbidities, or who have a BMI of 35 kg/m<sup>2</sup> or greater (or 120% of the 95th percentile for age and sex, whichever is lower) with clinically significant disease may be considered for bariatric surgery according to the American Academy of Pediatrics (Armstrong et al, 2019). U.S. Food and Drug Administration (FDA) premarket approval for the LAP-BAND<sup>®</sup> System indicates it is intended for severely obese adults. (The clinical study submitted to FDA for approval of the LAP-BAND was restricted to adults ages 18-55 years.)

Patients should have documented failure to respond to conservative measures for weight reduction prior to consideration of bariatric surgery, and these attempts should be reviewed by the practitioner prior to seeking approval for the surgical

procedure. As a result, some centers require active participation in a formal weight reduction program that includes frequent documentation of weight, dietary regimen, and exercise. However, there is a lack of evidence on the optimal timing, intensity, and duration of nonsurgical attempts at weight loss, and whether a medical weight loss program immediately preceding surgery improves outcomes.

Patients with a BMI of 50 kg/m<sup>2</sup> or more need a bariatric procedure to achieve greater weight loss. Thus, the use of adjustable gastric banding, which results in less weight loss, should be most useful as a procedure for patients with a BMI less than 50 kg/m<sup>2</sup>. Malabsorptive procedures, although they produce more dramatic weight loss, potentially result in nutritional complications, and the risks and benefits of these procedures must be carefully weighed in light of the treatment goals for each patient.

Patients who undergo adjustable gastric banding and fail to achieve adequate weight loss must show evidence of postoperative compliance with diet and regular bariatric visits prior to consideration of a second bariatric procedure.

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**Rationale:** This policy was developed in response to *Arkansas Act 109 for State and Public School Health Insurance program*.

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**CPT/HCPCS:**

- 43631 Gastrectomy, partial, distal; with gastroduodenostomy
- 43632 Gastrectomy, partial, distal; with gastrojejunostomy
- 43633 Gastrectomy, partial, distal; with Roux en Y reconstruction
- 43634 Gastrectomy, partial, distal; with formation of intestinal pouch
- 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)
- 43842 Gastric restrictive procedure, without gastric bypass, for morbid obesity; 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
- 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

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**Group specific policy will supersede this policy when applicable. This policy does not apply to the Wal-Mart Associates Group Health Plan participants or to the Tyson Group Health Plan**

**participants.**  
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