



**Subject:** Weight Loss Surgery

**Effective Date:** 1/00

**Revision Date:** 9/22

## DESCRIPTION

OSU Health Plans supports covered members with a spectrum of service for obesity and weight loss attempts. The coverage amounts and covered services will vary depending on the patient's Body Mass Index (BMI), comorbid conditions, and their personal weight loss history. These options do include surgical procedures. However, surgery should be considered as a tertiary option for individuals who have been unable to demonstrate successful weight loss through more conservative methods; therefore, appropriate alternative methods should and will be encouraged. If surgery is considered, a thorough screening and educational program will be utilized to increase the potential for successful outcomes and minimize as much as possible the occurrence of post-operative complications.

Obesity is increasingly prevalent in the United States, affecting females and males of all ages, all races, and all educational levels. Clinically severe, or morbid, obesity is generally defined as weighing at least twice the ideal body weight, or having a body mass index (BMI) of 40 kg/m<sup>2</sup> or 35 kg/m<sup>2</sup> with comorbidity. A recent study conducted by the Research Triangle Institute and the Centers for Disease Control and Prevention (CDC) determined that more than half of all Americans are either overweight or obese. The morbidly obese are at heightened risk for numerous health- and employment-related problems, and obesity-related diseases in the United States are significant public health issues.

These procedures are currently considered effective when combined with post-operative medical management:

- 1) The **Roux-en-Y gastric bypass** produces more significant and longer lasting weight loss and requires fewer revision surgeries due to mechanical failure of the bypass.
- 2) **Vertical banded gastroplasty (VBG)** has fewer nutritional and metabolic complications.
- 3) **Adjustable silicone gastric banding (ASGB)** has the least nutritional and metabolic complications.
- 4) **Gastric Sleeve** reduction of volume along length of the stomach

## CRITERIA

OSU Health Plan considers weight loss surgery (i.e., gastric bypass, gastric banding, gastric reduction) medically necessary when all the following criteria are met:

- Member meets one of the following BMI requirements and has been at that BMI for a minimum of 2 years:
  - BMI over 40
  - BMI over 35 with one or more severe obesity-related comorbidities:
    - Type II Diabetes Mellitus
    - Clinically significant obstructive sleep apnea (OSA) documented on polysomnogram
    - Medically refractory hypertension with systolic over 140 and/or diastolic over 90 despite concurrent use of 3 anti-hypertensive agents of different classes

- Documentation of any life threatening or serious medical condition that is directly weight related
- Letter from the patient's primary care doctor acknowledging their awareness that the client is seeking this procedure to facilitate subsequent medical care coordination
- Evidence of complete medical and dietary evaluations indicating appropriateness for bariatric surgery performed in the previous 12 months.
- Behavioral Health evaluation completed by an appropriate clinician performed in the previous 12 months that documents the all following:
  - The member has the ability to give informed consent
  - The member can comprehend the importance of follow-up medical care post-operatively
  - Symptoms of comorbid Behavioral Conditions that would compromise the member's surgical outcomes have been under control for at least 12 months
- Surgeon and/or surgical location is a Center of Excellence (ASMBS or ACS Level I designation)
- Successful participation of at least 6 months duration of weight loss programming consisting of the all following components within the past 24 months, 3 months must be consecutive\*:
  - One of the following:
    - Physician supervised nutrition and exercise program, to include all of the following documentation:
      - Focused medical evaluation related to obesity and causative factors, weight history, and past diet attempts; and
      - Dietitian consultation(s); and
      - Plan of care documenting the recommended low-calorie diet, increased physical activity and behavior modification, and
      - Detailed progress notes documenting the patient's compliance with the established plan of care as well as any barriers to achieving desired weight loss (minimum monthly); and
      - Behavioral health consultation for behavior modification as applicable; or
    - Pre-Surgery multi-disciplinary education program, to include dietary changes required for long-term success and an exercise regimen. Refer to the requirements for a physician-directed weight loss plan for minimum documentation requirements.
  - A post-op plan including the support system and exercise plan must be in place
- Member has completed bone growth (generally age 13 in girls and age 15 in boys, or older)
- Member has no specifically correctable cause of obesity
- All documentation requirements are provided, as applicable to the case (see below)

**\* Successful Completion of Pre-surgical program expectations:**

Prior to surgery, the patients are required to attend a series of instructional classes provided by a multidisciplinary treatment team advising them on key Weight Loss and Post-Surgical issues. The purpose of these classes is to ensure that patients via their support team have a thorough understanding of the risks, requirements and behaviors that are necessary to have the best chance of successful outcomes post-operatively.

The member is required to attend at least 6 months of programming in the two years prior to surgery, with at least 3 months consecutive attendance. Documentation proving attendance can include attendance sheets, clinical notes or written records from medical or nutritional experts. Commercial weight loss programs will be considered only if they cover all the areas of focus and the sessions are directed by clinicians.

These programs are expected to prepare the candidate thoroughly for success prior to and post operatively and should focus on weight loss surgery.

The OSU Health Plan considers second weight loss surgery attempts medically necessary when one of the following criteria is met:

- Second surgeries can be considered if the member meets the criteria above and the initial weight loss surgery was considered medically necessary, but the expected clinical results were not considered a success after at least two years post-op duration (i.e., the member did not lose and maintain at least 50% of excess weight).
- Conversion to a roux-en-y gastric bypass, if member has been compliant with prescribed nutrition and exercise program following the initial procedure.
- Revision of a primary bariatric surgery procedure that has failed due to dilatation of the gastric pouch, if the primary procedure was successful in inducing weight loss prior to pouch dilatation and the member has been compliant with a prescribed nutrition and exercise program following the initial procedure.

## **DOCUMENTATION REQUIREMENTS**

1. Any life threatening co-morbidity
2. Any recommended surgery prohibited by extreme obesity (e.g. total knee or hip replacement)
3. Diabetes status, with FBS, HgbA1c
4. Blood pressure readings confirming refractory hypertension
5. Pulmonary function test results recently
6. Ejection fraction results currently
7. X-rays, MRIs, CT, or Echo scans within last year indicating cardiac size
8. Medical records for the last 2 years
9. Testing to document thyroid status
10. Pre-operative, behavioral health, and dietary evaluations\*\*
11. Documentation from weight loss program

\*\* The assessment visit should include a multidisciplinary evaluation and recommendations, with a report that SPECIFICALLY addresses each of the above criteria and supplies the necessary documentation if obesity surgery is recommended. OSU Health Plan should receive a confidential copy of the complete evaluation, which should include a complete history and a weight history (age of onset, high and low weight within past 2 years, weight loss attempts, detailed documentation of existing comorbid conditions, medical risk factors, chemical abuse, current medications, physical activity level and patient expectations.) The physical examination should include current BMI, vital signs, and complete laboratory tests (including, TSH, lipids, LFTs, renal function and pregnancy test in females capable of reproduction.)

Before obesity surgery, it is recommended that a “contract” be drafted between the physician(s) and the patient providing for long-term postoperative follow-up to ensure the best possible outcome

## **EXCLUSIONS**

The following are not covered benefits:

- Liposuction
- Excision of excessive skin of thigh (thigh lift, thighplasty), leg, hip, buttock, arm (arm lift, brachioplasty), forearm or hand, submental fat pad
- Liquid or solid food supplements
- Exercise programs
- Exercise equipment
- Any weight loss procedure considered experimental or investigational by OSU Health Plan
- Vagal blocking therapy for obesity
- Bariatric surgery for the treatment of GERD in patients who do not meet the above criteria.
- Bariatric surgery for patients with a BMI <35 kg/m<sup>2</sup>
- Bariatric surgery for glycemic control independent of BMI criteria

- Bariatric surgery for patients with any of the following exclusions:
  - Reversible endocrine or other disorders that can cause obesity
  - Current drug or alcohol abuse
  - Uncontrolled, severe psychiatric illness
  - Lack of comprehension of risks, benefits, expected outcomes, alternatives, and lifestyles changes required with bariatric surgery
- Adjunctive omentectomy to bariatric surgery
- AspireAssist aspiration therapy
- “Band over bypass” or LASGB revision of prior Roux-en-Y gastric bypass
- "Band over sleeve" or LASGB revision of prior sleeve gastrectomy
- Bariatric surgery as a treatment for idiopathic intracranial hypertension
- Bariatric surgery as a treatment for infertility
- Bariatric surgery as a treatment for type-2 diabetes in persons with a BMI less than 35
- Conversion of a sleeve gastrectomy to a Roux-en-Y gastric bypass for the treatment of bile reflux
- Conversion to sleeve gastrectomy for hypoglycemia post-RYGB
- Gastric bypass as a treatment for gastroparesis
- Gastroplasty (“stomach stapling”)
- Laparoscopic gastric diversion with gastro-jejunal reconstruction for the treatment of GERD with esophagitis
- Laparoscopic gastric plication (laparoscopic greater curvature plication [LGCP], with or without gastric banding)
- Loop gastric bypass
- Mini gastric bypass
- Natural orifice transoral endoscopic surgery (NOTES) techniques for bariatric surgery including, but may not be limited to, the following:
  - Gastrointestinal liners (endoscopic duodenal-jejunal bypass, endoscopic gastrointestinal bypass devices; e.g., EndoBarrier and the ValenTx Endo Bypass System); or
  - Intragastric balloon (e.g., the Obalon Balloon System, and the ReShape Integrated Dual Balloon System); or
  - Mini sleeve gastrectomy; or
  - Restorative obesity surgery, endoluminal (ROSE) procedure for the treatment of weight regain after gastric bypass surgery; or
  - Transoral gastroplasty (TG) (vertical sutured gastroplasty; endoluminal vertical gastroplasty; endoscopic sleeve gastroplasty); or
  - Use of any endoscopic closure device (Over the Scope clip [OTSC] system set, Apollo OverStitch endoscopic suturing system, StomaphyX endoluminal fastener and delivery system) in conjunction with NOTES;
- Open adjustable gastric banding
- Prophylactic mesh placement for prevention of incisional hernia after open bariatric surgery
- Sclerotherapy for the treatment of dilated gastrojejunostomy following bariatric surgery
- Silastic ring vertical gastric bypass (Fobi pouch)
- Sleeve gastrectomy with single anastomosis duodeno-ileal bypass (SIPS)
- Vagus nerve blocking (e.g., the VBLOC device, also known as the Maestro Implant or the Maestro Rechargeable System)

## REASONS FOR PHYSICIAN REVIEWER DENIAL

The documentation provided does not meet the above specified criteria.

**NOTE:** If determined as not medically necessary and if member proceeds with having this procedure done, it is considered cosmetic and thus not a covered benefit

## DIAGNOSES WHICH MAY SUPPORT MEDICAL NECESSITY

E66.01	Morbid (severe) obesity due to excess calories
E66.2	Morbid (severe) obesity with alveolar hypoventilation
Z68.35	Body mass index [BMI] 35.0-35.9, adult
Z68.36	Body mass index [BMI] 36.0-36.9, adult
Z68.37	Body mass index [BMI] 37.0-37.9, adult
Z68.38	Body mass index [BMI] 38.0-38.9, adult
Z68.39	Body mass index [BMI] 39.0-39.9, adult
Z68.41	Body mass index [BMI] 40.0-44.9, adult
Z68.42	Body mass index [BMI] 45.0-49.9, adult
Z68.43	Body mass index [BMI] 50.0-59.9, adult
Z68.44	Body mass index [BMI] 60.0-69.9, adult
Z68.45	Body mass index [BMI] 70 or greater, adult

## CPT CODES COVERED IF CRITERIA ARE MET

43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	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	revision of adjustable gastric restrictive device component only
43772	removal of adjustable gastric restrictive device component only
43773	removal and replacement of adjustable gastric restrictive device component only
43774	removal of adjustable gastric restrictive device and subcutaneous port components
43775	longitudinal gastrectomy (ie, sleeve gastrectomy)
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843	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) <b>[Not covered when used for the SIPS procedure]</b>
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43847	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)
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	removal of subcutaneous port component only
43888	removal and replacement of subcutaneous port component only
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline

## CPT CODES NOT COVERED FOR INDICATIONS LISTED IN THIS POLICY [Incorrect for reporting bariatric surgery]

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 of pulse generator, includes programming
0313T	laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator
0314T	laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator

0315T	removal of pulse generator
0316T	replacement of pulse generator
0317T	neurostimulator pulse generator electronic analysis, includes reprogramming when performed
15876	Suction assisted lipectomy; head and neck
15877	trunk
15878	upper extremity
15879	lower extremity
43620	Gastrectomy, total; with esophagoenterostomy
43621	with Roux-en-Y reconstruction
43622	with formation of intestinal pouch, any type
43631	Gastrectomy, partial, distal; with gastroduodenostomy
43632	with gastrojejunostomy
43633	with Roux-en-Y reconstruction
43634	with formation of intestinal pouch
43635	Vagotomy when performed with partial distal gastrectomy
43659	Unlisted laparoscopy procedure, stomach
43999	Unlisted procedure, stomach

## REFERENCES AND ATTACHMENTS

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