Clinical Policy: Bariatric Surgery

Reference Number: AR.CP.MP.37
Date of Last Revision: 03/26

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

There are two categories of bariatric surgery: restrictive procedures and malabsorptive procedures. Gastric restrictive procedures include procedures where a small pouch is created in the stomach to restrict the amount of food that can be eaten, resulting in weight loss. The laparoscopic adjustable gastric banding (LAGB) and laparoscopic sleeve gastrectomy (LSG) are examples of restrictive procedures. Malabsorptive procedures bypass portions of the stomach and intestines causing incomplete digestion and absorption of food. Duodenal switch is an example of a malabsorptive procedure. Roux-en-y gastric bypass (RYGB), biliopancreatic diversion with duodenal switch (BPD-DS), single-anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S), and biliopancreatic diversion with gastric reduction duodenal switch (BPD-GRDS) are examples of restrictive and malabsorptive procedures.[1]

LAGB devices are currently not FDA approved for adolescents less than 18 years and are being used less for adolescents in favor of sleeve gastrectomy (SG).[2]

Policy/Criteria

I. It is the policy of health plans affiliated with Arkansas Health and Wellness, Arkansas Total Care, and QualChoice that bariatric surgery is **medically necessary** when the following criteria in **sections A *and* B** are met**:**

A. Medical history, meets all of the following:
   1. Age and body mass index (BMI) (meet criteria in a *or* b):
      a. Age ≥ 18 and one of the following (i or ii):
         1. BMI ≥ 32.5 kg/m^2 for South Asian, Southeast Asian, and East Asian adults or ≥ 35 kg/m^2 for all other ethnicities when laparoscopic adjustable gastric banding (LAGB), laparoscopic sleeve gastrectomy (LSG), laparoscopic Roux-en-y gastric bypass (RYGB), single anastomosis duodeno-ileal bypass (SADI)/ single-anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S), or laparoscopic biliopancreatic diversion with duodenal switch (BPD-DS)/biliopancreatic diversion with gastric reduction duodenal switch (BPD-GRDS) is requested;
         2. BMI ≥ 27.5 and < 32.5 kg/m^2 for South Asian, Southeast Asian, and East Asian adults or ≥ 30 and < 35 kg/m^2, for all other ethnicities when LAGB, LSG, laparoscopic RYGB, SADI/SADI-S, or BPD-DS/BPD-GRDS is requested and at least one of the following:
            a) Type 2 diabetes mellitus (DM);
            b) One of the following obesity related co-morbidities has not improved despite using nonsurgical weight loss methods:
               i) Hypertension;
               ii) Dyslipidemia;
               iii) Obstructive sleep apnea;
               iv) Obesity-hypoventilation syndrome/Pickwickian syndrome;

v) Nonalcoholic fatty liver disease or nonalcoholic steatohepatitis;
vi) Pseudotumor cerebri;
vii) Coronary artery disease;
viii) Gastroesophageal reflux disease;
ix) Asthma;
x) Venous stasis disease;
xi) Bone and joint diseases;
xii) Disqualification from other specialty surgeries due to obesity (i.e., joint arthroplasty, abdominal wall hernia repair, or organ transplantation);
xiii) Chronic kidney disease;
xiv) Infertility;
xv) Polycystic ovarian syndrome;
xvi) Atrial fibrillation;
xvii) Heart failure;

b. Age < 18 years, LSG or laparoscopic RYGB is requested, and BMI ≥ 35 kg/m² or 120% of the 95th percentile (whichever is lower);

B.Preoperative evaluation and medical clearance requirements

1. A physician order that includes a statement that identified the BMI and any associated comorbid conditions, describes the treatment plan, and attests that the treatment is medically necessary according to the qualifications and treatment standards established by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons.
2. An attestation from the member/enrollee:
   a. They have participated in a weight loss program, AND
   b. Received preoperative medical and mental health evaluations and clearances,
   c. Received preoperative education that addresses the risks, benefits, realistic expectations, and the need for long-term follow-up and adherence to behavioral modifications, AND
   d. Received a copy of the treatment plan that describes the preoperative needs and postoperative needs of an individual undergoing bariatric surgery, OR
3. In lieu of the above list of requirements a member/enrollee may attest to the completion of a multidisciplinary surgical preparation program that is also signed by the healthcare provider.
4. The following are recommended requirements, **the provider is not required to provide documentation, however, the plan will accept this documentation in lieu of an attestation from the member/enrollee.** The member/enrollee should complete these requirements within six months of the scheduled surgery, and the timeframe for participation in any requirement should be no more than 90 days.
   a. Medical clearance by member/enrollee's PCP if no current cardiac or pulmonary comorbid conditions or clearance by cardiologist and/or pulmonologist for those with such conditions; AND
   b. Nutritional evaluation by a qualified provider such as a physician, physician assistant, advanced registered nurse practitioner or registered dietitian; AND
   c. Age-appropriate psychiatry/psychology consultation stating that member/enrollee is a good candidate for bariatric surgery and that any mental health disorders are adequately managed.

II. It is the policy of health plans affiliated with Arkansas Health and Wellness, Arkansas Total Care, and QualChoice that *repeat bariatric surgery* is considered medically necessary for one of the following:

A. To correct complications from a previous bariatric surgery, such as obstruction or strictures (could include conversion surgeries to LSG or RYGB for adults or adolescents; or BPD-DS for adults);

B. Conversion from LAGB to an LSG, RYGB, SADI-S, or BPD-DS; or revision of a primary procedure that has failed due to dilation of the gastric pouch when all of the following criteria are met:

1. All criteria listed above for the initial bariatric procedure are met again;
2. Previous surgery for morbid obesity was at least two years prior to repeat procedure;
3. Weight loss from the initial procedure was less than 50% of the member/enrollee's excess body weight at the time of the initial procedure;
4. If the conversion is requested due to removal of an eroded laparoscopic adjustable band, at least two months have passed between the band removal and the subsequent bariatric procedure;
5. Documented compliance with previously prescribed postoperative nutrition and exercise program;
6. Supporting documentation from the provider should also include a clinical explanation of the circumstances as to why the procedure failed;

C. Conversion of SG to RYGB for the treatment of gastro-esophageal reflux disease (GERD) when anti-reflux medical therapy has been tried and failed;

D. Conversion of SG to RYGB or BPD-DS as a bridging procedure for BMI $\geq$ 50 kg/m^2.

III. It is the policy of health plans affiliated with Arkansas Health and Wellness, Arkansas Total Care, and QualChoice that the current medical literature is inadequate to determine the safety, efficacy, and long-term outcomes for the following bariatric surgery procedures:

A. Distal gastric bypass (very long limb gastric bypass);

B. Mini gastric bypass–one anastomosis gastric bypass (e.g., mini-gastric bypass, one-anastomosis gastric bypass, single anastomosis gastric bypass, omega loop gastric bypass);

C. Laparoscopic re-sleeve gastrectomy (LRSG) performed after the resulting gastric pouch is primarily too large or dilates after the original LSG;

D. Fobi pouch;

E. Laparoscopic greater curvature plication (Gastric Imbrication);

F. Stomach aspiration therapy (e.g., AspireAssist);

G. Endoscopic Suture Revisions post bariatric surgery;

H. Gastric plication/ Endoluminal vertical gastroplasty;

I. Endoscopic gastrointestinal bypass devices (EGIBD);

J. Endoscopic sleeve gastroplasty;

K. Transoral endoscopic surgery;

L. Vagus Nerve Blocking (e.g., Maestro);

M. Gastric balloon (e.g., ReShape Duo, Orbera intragastric balloon, Obalon Balloon).

IV. It is the policy of health plans affiliated with Arkansas Health and Wellness, Arkansas Total Care, and QualChoice that the following bariatric surgery procedures are considered **not medically necessary**, due to potential complications and a lack of positive outcomes:
A. Biliopancreatic diversion (BPD) procedure (also known as the Scopinaro procedure);
B. Jejunoileal bypass (jejuno-colic bypass);
C. Vertical Banded Gastroplasty (VBG);
D. Gastric pacing/gastric electrical stimulation;
E. Gastric wrapping.

Background

Individuals with clinically severe obesity are at risk for increased mortality and multiple co-morbidities. These co-morbidities include hypertension, hypertrophic cardiomyopathy, hyperlipidemia, diabetes, cholelithiasis, obstructive sleep apnea, hypoventilation, degenerative arthritis and psychosocial impairments. The majority of severely obese patients losing weight through non-operative methods alone regain all the weight lost over the next five years. Surgical treatment is the only proven method of achieving long term weight control for the morbidly obese. Eating behaviors after surgery improve dramatically due to the restricted size of the stomach, allowing only small amounts of food to be taken in at a time.[3,4]

The type of surgical procedure performed should be based on body mass index (BMI), comorbidity profile, treatment goals, surgeon's expertise, patient preference and risk stratification.[5] The most commonly performed bariatric procedure in the United States is laparoscopic sleeve gastrectomy (LSG), followed by laparoscopic Roux-en-Y gastric bypass (RYGB), laparoscopic adjustable gastric banding (LAGB), and biliopancreatic diversion with duodenal switch (BPD-DS).[5] The sleeve gastrectomy (SG) continues to trend upwards due to lower rates of complications and nutritional deficiencies, while maintaining comparable weight loss and metabolic disease outcomes.[5] It was the most commonly performed bariatric procedure in the United States and in the world in 2016, and laparoscopic surgery is the preferred methodology.[1]

The single anastomosis duodenoileal bypass (SADI), also known as single-anastomosis duodenal switch (SADS) and most descriptively, single-anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S), combines restrictive, malabsorptive, and likely hormonal mechanisms for weight loss. The sleeve is created first, and the duodenum is divided after the pylorus. SADI creates an anastomosis between the side of the distal ileum and the end of the sleeve-like gastric pouch/duodenum.[1]

The ASMBS endorses SADI-S as an appropriate primary metabolic bariatric procedure.[1] Per the ASMBS, the SADI-S procedure is fundamentally a variant of the duodenal switch (DS) operation, in which the transected duodenum is anastomosed to a loop of ileum, as opposed to the classic DS in which a Roux-en-Y configuration is used. However, the ASMBS notes the publication of long-term safety and efficacy outcomes is still needed and is strongly encouraged, particularly with published details on SG size and common channel length. There remain concerns about intestinal adaptation, nutritional issues, optimal limb lengths, and long-term weight loss/regain after this procedure. As such, ASMBS recommends a cautious approach to the adoption of this procedure, with attention to ASMBS-published guidelines on nutritional and metabolic support of bariatric patients, in particular for DS patients.[1,19]

The International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) considers SADI-S safe and effective based on short-term data from studies but recommends that long-term follow up be continued and that randomized controlled trials be performed in the near future.[19] According to the IFSO, SADI-S is considered an effective option for patients with severe obesity, either as an initial procedure or as a revisional surgery following failed sleeve gastrectomy.[42] In a 2021 updated statement, IFSO emphasized that SADI-S can result in maintaining significant weight loss for the obese individual, but nutritional deficiencies are a long-term safety concern, and patients need to be aware of this and encouraged to remain in long-term multidisciplinary care.[19] In its 2024 updated statement, IFSO concluded that SADI-S is a safe and reproducible procedure, associated with low rates of both early and late complications, and provides significant, sustained weight loss over a medium- to long-term follow-up of five years. However, data beyond six years remains limited. Even with the inclusion of additional retrospective studies and one RCT, the overall level of evidence remains largely unchanged. Therefore, to strengthen the quality of evidence, IFSO supports participation in both national and international registries, along with efforts to publish long-term outcomes and conduct RCTs.[41]

Additionally, the National Institute for Health and Care and Excellence (NICE) encourages further research into SADI-S with a focus on long-term outcomes.[5] NICE recommendations also state that there are well-recognized complications when treating morbid obesity with SADI-S, including the possibility of serious metabolic complications.[5] NICE states, "this procedure should only be used with special arrangements for clinical governance, consent and audit or research."[5]

The success of the bariatric surgery relies on the motivation and dedication to the program of the patient. The patient must be able to participate in the treatment and long-term follow up required after surgery. Studies have shown that about 10% of patients may have unsatisfactory weight loss or regain much of the weight they have lost. This may occur due to frequent snacking on high-calorie foods or lack of exercise. Technical problems that may occur include a stretched pouch due to overeating following surgery. Ensuring patients are motivated to lose weight can help prevent some of these issues.

Maximum weight loss usually occurs between 18 and 24 months postoperatively. The average weight loss at five years ranges from 48 to 74% after gastric bypass and 50 to 60% following gastric banding. Several studies have follow-up from five to 15 years with these patients maintaining weight loss of 50 to 60% of excess weight.

The Lap Band is a small bracelet-like band placed around the top of the stomach to produce a small pouch about the size of a thumb. The size of the outlet is controlled by a circular balloon inside the band that can be inflated and deflated with saline solution through an access port placed under the skin. The more inflated the balloon, the narrower the opening and slower passage of food to the rest of the stomach.[1]

RYGB creates a small stomach pouch, bypassing most of the stomach, duodenum, and upper intestine.[1] Weight loss occurs through restriction of food intake and by decreasing the absorption

of food by re-routing food directly from the pouch into the small intestine. With over 25 years of experience with RYGB in adults, the long-term results are well established for weight loss and improvement in comorbidities, and this surgery now accounts for approximately 20% of bariatric procedures in adolescents.[6]

BPD-DS is a complex operation that includes removing a large portion of the stomach to promote smaller meal sizes, re-routing of food away from much of the small intestine to prevent partial absorption of food, and re-routing of bile and other digestive juices that impair digestion. The operation bypasses most of the duodenum but leaves a small portion for food and the absorption of some vitamins and minerals. BPD-DS produces significant weight loss but has a greater risk of long-term complications due to decreased absorption of food, vitamins, and minerals.[1]

American Society for Metabolic and Bariatric Surgery (ASMBS)
Updated guidelines from the ASMBS recommend metabolic and bariatric surgery for patients with BMI ≥ 35 kg/m^2, regardless of presence, absence, or severity of co-morbidities and for patients with BMI of 30 to 34.9 kg/m^2 who do not achieve substantial, durable weight loss or co-morbidity improvement with reasonable nonsurgical methods, bariatric surgery should be considered. In this population, surgical intervention should be considered after failure of nonsurgical treatments. For patients with type II diabetes, bariatric and metabolic surgery is now recommended for those with BMI ≥ 30 kg/m^2. LAGB, LSG, and RYGB have been shown to be well-tolerated and effective treatments. Safety and efficacy of these procedures in low-BMI patients appear to be similar to results in patients with severe obesity. Currently, the best evidence for bariatric and metabolic surgery for patients with class I obesity and co-morbid conditions exists for patients in the 18 to 65 age group.[4,7]

Bariatric Surgery in Adolescents
Weight loss surgery has been performed in small groups of adolescents since the 1970s. Recent data has shown a significant increase in the rate since 2000.[2] It is likely that we will continue to see a rise in the rate of adolescents undergoing weight loss surgery with the current pediatric obesity epidemic. Children and adolescents who are severely obese are at risk for the same mortality and co-morbidities as adults.[8,9] These co-morbidities include hypertension, hypertrophic cardiomyopathy, hyperlipidemia, diabetes, cholelithiasis, obstructive sleep apnea, depression and impaired quality of life. In addition, children in the BMI category ≥ 35 kg/m^2 will almost always remain obese, and 65% will have a BMI ≥ 40 as an adult.[6]

Changes in diet and physical activity must be attempted prior to weight loss surgery in adolescents. A multi-disciplinary, family-based approach should be undertaken to support a staged weight loss plan.[10] However, studies suggest that dietary and behavioral interventions rarely result in significant and sustained weight loss in adolescents. This same multi-disciplinary and family approach must be taken when evaluating and planning for bariatric surgery in an adolescent.[8,9]

Recently updated guidelines from the ASMBS on pediatric metabolic and bariatric surgery conclude that metabolic and bariatric surgery (MBS) is a proven, effective treatment for severe obesity disease in adolescents and should be considered standard of care. Treatment of severe

obesity in adolescents clearly requires a multidisciplinary approach where MBS should not be consigned to the treatment of last resort. Rather, when considered appropriate and within the clinical best practice guidelines, MBS should be readily offered to adolescents with obesity to effectively reverse co-morbidities and achieve overall wellness. Prior weight loss attempts, Tanner stage, and bone age should not be barriers to definitive treatment.[2,4]

Investigational Procedures
Long-limb or Distal Gastric Bypass for Superobesity: A randomized controlled trial (RCT) was completed by Svanevik et al., but only perioperative outcomes have been reported thus far. Svanevik et al. found that in superobese patients with BMI between 50 and 60 kg/m^2, distal gastric bypass was associated with longer operating time and more severe complications resulting in reoperation than proximal gastric bypass.[11] There is increased risk of adverse nutritional outcomes with longer limb gastric bypass. At this time the long-limb or distal gastric bypass for superobesity is considered investigational, until more long-term studies can be done which reflect better outcomes than existing procedures.

Loop Gastric Bypass (Mini Gastric Bypass, one-anastomosis gastric bypass): The mini gastric bypass has not been universally accepted due to higher rates of alkaline bile reflux and limited long-term research. More long-term research is needed to solidify mini gastric bypass surgery's position as a viable bariatric surgery option.[1]

Re-Sleeve Gastrectomy for Failed Laparoscopic Sleeve Gastrectomy: In 2012 Iannelli et al. noted that laparoscopic sleeve gastrectomy (LSG) was rapidly accepted as a valuable bariatric procedure before its effectiveness on weight loss in the long-term is clearly demonstrated.[12] The authors report a feasibility study including 13 patients undergoing a redo LSG for either progressive weight regain after initial weight loss or insufficient weight loss.[13] AlSabah et al. describe 24 patients who underwent re-sleeve laparoscopic gastrectomy after an initial LSG. Compared to 12 patients that initially had LSG, which was converted to LRYGB, results were similar, with no significant differences in percent of excess weight loss at one year.[14] They conclude that larger and longer follow-up studies are needed to verify results.[14]

Fobi Pouch or Silastic® Ring: The Fobi Pouch bariatric operation for obesity is a combination of stomach reduction and gastric bypass. The Silastic ring is placed around the vertically constructed gastric pouch above the anastomosis between the pouch and the intestinal Roux limb. Possible long term nutritional deficiencies involve fat soluble vitamin deficiencies of Calcium, Iron, B12, and Folic Acid. Patients are placed on nutritional supplements for the rest of their lives, and yearly monitoring is needed. The Fobi Pouch gastric bypass takes about double the time that a vertical banded gastroplasty operation takes. There is limited research on the outcomes of the Fobi pouch versus other bariatric surgery procedures.[15]

Gastric Imbrication: Fried et al. completed a three year RCT on the safety and efficacy of laparoscopic adjustable gastric banding with and without imbrication sutures.[16] The results of the RCT have demonstrated that single anastomosis gastric bypass (SAGB) combined with a conservative approach to band adjustments and limited retrogastric dissection is effective and safe with and without imbrication sutures. Not using imbrication sutures results in significant benefits in operative speed with comparable clinical weight loss and intermediate term safety.[16]

Sharma et al. conducted a randomized, double blinded trial comparing LSG and laparoscopic gastric imbrication (LGI). They found no differences in weight, age, or BMI preoperatively at six months or three years between the two groups.[17]

The AspireAssist System (AspireAssist) was FDA approved in 2016. It is a weight loss device comprised of an endoscopically placed percutaneous gastrostomy tube and an external device to facilitate drainage of about 30% of each meal consumed. It is meant to be used in conjunction with diet and exercise. In 2017 a one-year RCT was performed comparing results of 207 patients treated with AspireAssist.[1] The treatment group (n=137) received AspireAssist and lifestyle counseling, and the control group (n=70) received lifestyle counseling alone. Compared to the control group, those who received the AspireAssist and counseling lost more weight. 58.6% of participants in the AspireAssist group, and 15.3% of participants in the Lifestyle Counseling group lost at least 25% of their excess body weight ($P<0.001$).[1] Additionally, a prospective observational study was conducted on 25 patients, and by the end of the two-year observation period, only 15 patients were still in the study. They concluded that AspireAssist is an efficient and safe treatment for obesity. There is no research on AspireAssist versus other bariatric surgery procedures.[18]

To enhance weight loss, the following endoscopic procedures have been attempted to promote restriction of the pouch or stoma. These revisions have included: sclerotherapy of the site using 6 to 30 mL of sodium morrhuate injected circumferentially; tissue plication systems to reduce the size of the gastrojejunostomy and the gastric pouch; revisional surgery using a tissue plication device known as StomaPhyX to reduce the pouch size; and application of the endoclip to reduce the size of the gastrojejunal anastomosis. There is a lack of long-term outcomes for endoscopic revisions post RYGB.[1]

Endoluminal vertical gastroplasty/gastric plication is an endoscopic approach for suturing the stomach that offers the potential to perform gastric-restrictive procedures endoluminally. The anterior and posterior walls of the stomach are suctioned together, then held in place by either a stapler or T-fastener device to create a tube of stomach similar to the sleeve gastrectomy.[1]

Endoscopic gastrointestinal bypass devices (EGIBD) are barrier devices deployed to prevent luminal contents from being absorbed in the proximal small intestine (e.g., ValenTX, EndoBarrier). Data are still lacking about the longevity of these endobarriers and their outcomes once the barrier is removed.[1]

Not Medically Necessary Procedures
Biliopancreatic Diversion (BPD) Procedure (Scopinaro procedure): The biliopancreatic diversion (BPD) is a malabsorptive procedure that was introduced as a solution to the high rates of liver failure resulting from bowel exclusion in the jejunoileal bypass. The procedure consists of a partial gastrectomy and gastroileostomy with a long segment of Roux limb and a short common channel, resulting in fat and starch malabsorption. BPD also has a restrictive component. The BPD/DS procedure differs from the BPD in the portion of the stomach that is removed, as well as preservation of the pylorus. This allows more forward flow of the contents of the biliopancreatic limb and avoids the complications of stasis that plagued the jejunoileal bypass

(JIB). It is associated with fewer complications than BPD alone. BPD/DS is a complex procedure that is only performed at a few centers in the U.S.[1]

Jejunoileal Bypass or Jejunoileal Intestinal Bypass (JIB): The jejunoileal bypass (also called the intestinal bypass) is performed by dividing the jejunum close to the ligament of Treitz and connecting it a short distance proximal to the ileocecal valve, thereby diverting a long segment of small bowel, resulting in malabsorption. This procedure is no longer performed due to the high complication rate and frequent need for revisional surgery. Per the American Society for Metabolic & Bariatric Surgery, the JIB is no longer a recommended bariatric surgical procedure. The lessons learned from the JIB include the crucial importance of long-term follow-up and the dangers of a permanent, severe and global malabsorption.[1]

Vertical Banded Gastroplasty (VBG): VBG has fallen out of favor as a restrictive procedure for severe obesity, due largely to the advantages of adjustable gastric banding.[1] VBG requires division of the stomach or intestinal resection, while LAGB does not. In addition, the staples used in VBG may break down and cause weight regain, and VBG requires the use of prosthetic mesh that may increase the incidence of stomach stenosis. Centers for Medicare and Medicaid Services (CMS) states in their National Coverage Determination for bariatric surgery for treatment of co-morbid conditions related to morbid obesity that "VBG procedures are essentially no longer performed."[20]

Gastric Balloon: Previous endoscopic technologies used to treat obesity endoscopically, such as the gastric balloon, had limited exposure in the U.S. and were removed from the market because of associated complications, such as balloon deflation with migration and resultant small intestinal obstruction.

Gastric Pacing: A number of procedures have been investigated for weight loss surgery but have not been totally accepted by the surgical community. Gastric pacing has been performed in several trials but has not been shown to have any long-term effect and has been abandoned.

Gastric Wrapping: A gastric wrap is minimally invasive surgery and involves folding the stomach in on itself and then the edges are stitched to turn the stomach into a narrow tube, therefore restricting the amount of food that can be consumed. This surgery is new and not widely offered, and there is a paucity of peer-reviewed scientific literature on this procedure.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT codes that support medical necessity

CPT®* Codes	Description
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43770*	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43848*	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only
43999	Unlisted procedure, stomach

*Some codes may be used for both medically necessary and not medically necessary indications.

CPT codes that do not support medical necessity

CPT®* Codes	Description
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon

CPT®* Codes	Description
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)
43632	Gastrectomy, partial, distal; with gastrojejunostomy
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver

HCPCS codes that support medical necessity

HCPCS Codes	Description
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline

Reviews, Revisions, and Approvals	Revision Date	Approval Date
New Policy	9/25	04/25
Updated Description to include single-anastomosis duodenoileal bypass (SADI)/single-anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S). Added SADI/SADI-S to Criteria I.A.1.a.i. and to Criteria I.A.1.a.ii. For age ≥ 18 and BMI ≥ 27.5 and < 32.5 kg/m^2 for South Asian, Southeast Asian, and East Asian adults or ≥ 30 and < 35 kg/m^2: removed indication I.A.1.a.ii.a) for continued obesity despite prior attempts at weight loss. Removed Criteria I.A.1.b.i. regarding BMI ≥ 40 kg/m^2 for age <18 years. Removed severe comorbidities listed in Criteria I.A.1.b.ii. for age <18 years with BMI ≥ 35 kg/m^2. In Criteria I.B.1, changed "Medical clearance by member/enrollee's PCP if no current cardiac or pulmonary comorbid conditions or clearance by cardiologist and/or pulmonologist for those with such conditions" to "medical evaluation from physician other than a surgeon…." SADI-S added to Criteria II.B. as a medically necessary procedure following conversion from LAGB. Removed SADI from Criteria III.I. Background updated so	10/25	10/25

Reviews, Revisions, and Approvals	Revision Date	Approval Date
that SADI/SADI-S is no longer listed as an investigational procedure. Added CPT code 43999 for SADI-S procedure. References reviewed and updated. Reviewed by external specialist.		
Annual review. Removed Criteria III.F. regarding LAP-BAND when BMI is 30 to 35 with or without comorbid conditions. Coding and descriptions reviewed. References reviewed and updated.	03/26	03/26

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to

applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.