MASSACHUSETTS

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Medical Policy

Medical and Surgical Management of Obesity including Anorexiants

Table of Contents

Policy Number: 379

BCBSA Reference Number: 7.01.47 (For Plan internal use only)

Related Policies

- Gastric Electrical Stimulation, #636
- Surgical and Transesophageal Endoscopic Procedures to Treat Gastroesophageal Reflux Disease, #920
- Drugs for Weight Loss, #572

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Surgical Management of Obesity Services Preauthorization Request Form
Providers, please complete the form. **Click here for the Surgical Management of Obesity Services preauthorization request form (#047).**

The following bariatric surgeries may be considered **MEDICALLY NECESSARY** for obesity that has not responded to conservative measures in individuals who meet the "Patient Selection Criteria" described in this policy:

Bariatric Surgery in Adults with Class 3 Obesity (BMI ≥ 40 kg/m^2)

The following bariatric surgical procedures may be considered **MEDICALLY NECESSARY** for the treatment of class 3 obesity (BMI ≥ 40 kg/m^2) in adults (ages 18 and older) who have failed weight loss by conservative measures:

- Open gastric bypass using a Roux-en-Y
- Laparoscopic gastric bypass using a Roux-en-Y
- Laparoscopic adjustable gastric banding
- Open or laparoscopic sleeve gastrectomy (SG), **AND**
- Open or laparoscopic biliopancreatic bypass/diversion (ie, Scopinaro procedure) with duodenal switch (DS).

Bariatric Surgery in Adults with Class 2 Obesity (BMI ≥ 35 to 39.9 kg/m^2)

The following bariatric surgery procedures may be considered **MEDICALLY NECESSARY** for the treatment of class 2 obesity in individuals with at least 1 obesity-related comorbid condition* who have failed weight loss by conservative measures:

- Open gastric bypass using a Roux-en-Y,
- Laparoscopic gastric bypass using a Roux-en-Y,
- Laparoscopic adjustable gastric banding,
- Sleeve gastrectomy (SG), and
- Open or laparoscopic biliopancreatic bypass/diversion (ie, Scopinaro procedure) with duodenal switch (DS).

***Weight-Related Complications**

Clinical Practice Guidelines list the following conditions weight-related complications, defined as conditions caused by or exacerbated by excess adiposity:[1],

- Asthma
- Cardiovascular disease
- Certain types of cancer (eg, colorectal cancer)
- Diabetes mellitus, Type 2
- Dyslipidemia
- GERD
- Hypertension
- Infertility
- Male hypogonadism
- Mental health (depression)
- Metabolic syndrome
- Nonalcoholic fatty liver disease (nonalcoholic fatty liver and nonalcoholic steatohepatitis)
- Obstructive sleep apnea
- Osteoarthritis
- Polycystic ovarian syndrome
- Prediabetes
- Stroke
- Urinary stress incontinence

Bariatric surgery should be performed in appropriately selected individuals, by surgeons who are adequately trained and experienced in the specific techniques used, and in institutions that support a comprehensive bariatric surgery program, including long-term monitoring and follow-up postsurgery. (see Policy Guidelines for bariatric surgery selection criteria).

Bariatric Surgery in Individuals with Class 1 Obesity (BMI ≥ 30 to 34.9 kg/m^2) and Type 2 Diabetes

For individuals with Class 1 obesity (BMI ≥ 30 to 34.9 kg/m^2) and type 2 diabetes, the following bariatric surgery procedures may be considered **MEDICALLY NECESSARY** in adults who have failed weight loss by conservative measures:

- Biliopancreatic diversion with DS,
- Laparoscopic adjustable gastric banding,
- Roux-en-Y gastric bypass, and
- Sleeve gastrectomy.

Bariatric surgery is considered **INVESTIGATIONAL** for individuals with Class 1 obesity who do not have diabetes.

Bariatric surgery is considered **INVESTIGATIONAL** for individuals with a BMI less than 30 kg/m^2.

The following bariatric surgical procedures are considered **INVESTIGATIONAL** for the treatment of obesity:

- Vertical-banded gastroplasty
- Gastric bypass using a Billroth II procedure (mini-gastric bypass)
- Biliopancreatic diversion (BPD) without duodenal switch (DS)
- Long limb gastric bypass (ie, >150 cm)
- Two-stage bariatric surgery procedures (eg, sleeve gastrectomy as initial procedure followed by BPD at a later time)
- Laparoscopic gastric plication
- Single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SG) (SADI-S)
- One anastomosis gastric bypass[1]
- Jejunoileal bypass[1]
- Horizontal gastric partitioning[1]
- Gastric wrapping[1]
- Gastric Electric Stimulation for the treatment of obesity (Gastric pacemaker).[1]

Revision Bariatric Surgery

Revision surgery to address perioperative or late complications of a bariatric procedure is considered **MEDICALLY NECESSARY**. These include but are not limited to, staple line failure, obstruction, stricture, nonabsorption resulting in hypoglycemia or malnutrition, weight loss of 20% or more below ideal body weight, and band slippage that cannot be corrected with manipulation or adjustment.

Revision of a primary bariatric procedure that has failed due to dilation of the gastric pouch or dilation proximal to an adjustable gastric band (documented by upper gastrointestinal examination or endoscopy) is considered **MEDICALLY NECESSARY** if the initial procedure was successful in inducing weight loss prior to pouch dilation, and the individual has been compliant with a prescribed nutrition and exercise program.

Revision surgery to address severe gastroesophageal reflux disease refractory to medical treatment is considered **MEDICALLY NECESSARY**.

Bariatric Surgery in Adolescents

Bariatric surgery in adolescents (ages 12-18, who may not yet have completed bone growth) may be considered **MEDICALLY NECESSARY** according to similar weight-based criteria used for adults, but greater consideration should be given to psychosocial and informed consent issues. Individuals must meet the "Patient Selection Criteria" described in this policy. In addition, any devices used for bariatric surgery must be in accordance with the FDA-approved indications.

Bariatric Surgery in Preadolescent Children

Bariatric surgery is considered **INVESTIGATIONAL** for the treatment of obesity in preadolescent children.

Concomitant Hiatal Hernia Repair with Bariatric Surgery

Repair of a hiatal hernia at the time of bariatric surgery may be considered **MEDICALLY NECESSARY** for individuals who have a preoperatively-diagnosed hiatal hernia with indications for surgical repair.

The Society of American Gastrointestinal and Endoscopic Surgeons have issued evidence-based guidelines for the management of hiatal hernia. Recommendations for indications for repair are as follows:

- Repair of a type I hernia [sliding hiatal hernias, where the gastroesophageal junction migrates above the diaphragm] in the absence of reflux disease is not necessary (moderate quality evidence, strong recommendation).
- All symptomatic paraesophageal hiatal hernias should be repaired (high quality evidence, strong recommendation), particularly those with acute obstructive symptoms or which have undergone volvulus.

- Routine elective repair of completely asymptomatic paraesophageal hernias may not always be indicated. Consideration for surgery should include the patient's age and comorbidities (moderate quality evidence, weak recommendation).

Repair of a hiatal hernia that is diagnosed at the time of bariatric surgery, or repair of a preoperatively diagnosed hiatal hernia in individuals who do not have indications for surgical repair is considered **INVESTIGATIONAL**.

Endoscopic Procedures

The following endoscopic procedures are considered **INVESTIGATIONAL** as a primary bariatric procedure or as a revision procedure, (ie, to treat weight gain after bariatric surgery to remedy large gastric stoma or large gastric pouches) including but not limited to:

- Insertion of the StomaphyX™ device
- Endoscopic gastroplasty
- Use of an endoscopically placed duodenojejunal sleeve
- Intragastric balloons,
- Single Anastomosis Duodenal-ileal switch (SADI-s)[1],
- Apollo Device[1], **AND**
- Aspiration therapy device.

POLICY GUIDELINES

Bariatric surgery should be performed in appropriately selected individuals, by surgeons who are adequately trained and experienced in the specific techniques used, and in institutions that support a comprehensive bariatric surgery program, including long-term monitoring and follow-up postsurgery.

Bariatric Surgery Selection Criteria

Adults over the age of 18 or who have documented complete bone growth are eligible for obesity surgery if **ALL** of the following criteria are met:

- The physician has indicated that the patient:
  - Is a well informed and motivated patient with acceptable operative risks, **AND**
  - Has a strong desire for substantial weight loss, **AND**
  - Has failed other non-surgical approaches to long-term weight loss. These approaches (ie, diet and exercise plans, behavioral changes, etc.) and duration are up to the surgeon's discretion, **AND**
  - Is enrolled in a program which provides pre-op and post-op multidisciplinary evaluation and care including behavioral health, nutrition, and medical management **AND**
  - The patient is morbidly obese with a BMI > 40kg/m².

  OR
- The individual has a **BMI >35kg/m²** and the physician has indicated that the individual has **one or more** of the following severe obesity-related complications:
  - Obstructive sleep apnea
  - Obesity-hypoventilation syndrome
  - Pickwickian syndrome
  - Nonalcoholic fatty liver disease or nonalcoholic steatohepatitis
  - Pseudotumor cerebri
  - Gastroesophageal reflux disease
  - Asthma
  - Venous stasis disease
  - Severe urinary incontinence
  - Debilitating arthritis or considerably impaired quality of life
  - Obesity related cardiomyopathy
  - At least Stage 1 Hypertension based on JNC-VII (SBP >140 and/or DBP >90) after combination pharmacotherapy
  - Coronary artery disease, **OR**

- Obesity related pulmonary hypertension

OR

- The individual has a BMI >30kg/m^2 and has type 2 diabetes.

Repeat Surgical Procedures

Repeat surgical procedures for revision or conversion to another surgical procedure is considered **MEDICALLY NECESSARY** for individuals who regained weight after the initial surgery or for inadequate weight loss (unrelated to a surgical complication of a prior procedure).[1]

Non-procedural Treatments for Obesity

The physician-directed visits and testing aspects of multi-faceted dietary programs such as Health Management Resources may be considered **MEDICALLY NECESSARY**.[1]

Non-physician directed and food replacement or supplement components of multi-faceted dietary programs such as Health Management Resources are considered **NOT MEDICALLY NECESSARY**.[1]

The following medical and pharmaceutical treatments for obesity are considered **NOT MEDICALLY NECESSARY**:[1]

- Multi-faceted dietary programs such as Optifast, and Medifast
- Orlistat ™ (Xenical ®) because it may be purchased over the counter (alli ™) without a prescription
- Anorexiants.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required** for surgical services. Prior authorization is **not required** for medical services.
Commercial PPO	Prior authorization is **required** for surgical services. Prior authorization is **not required** for medical services.

Requesting Prior Authorization Using Authorization Manager

Providers will need to use Authorization Manager to submit initial authorization requests for services. Authorization Manager, available 24/7, is the quickest way to review authorization requirements, request authorizations, submit clinical documentation, check existing case status, and view/print the decision letter. For commercial members, the requests must meet medical policy guidelines.

To ensure the request is processed accurately and quickly:

- Enter the facility's NPI or provider ID for where services are being performed.
- Enter the appropriate surgeon's NPI or provider ID as the servicing provider, *not* the billing group.

Authorization Manager Resources

- Refer to our Authorization Manager page for tips, guides, and video demonstrations.

Complete Prior Authorization Request Form for Surgical Management of Obesity (047) using Authorization Manager.

For out of network providers: Requests should still be faxed to 888-282-0780.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

CPT Codes

CPT codes:	Code Description
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)
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)

ICD-10 Procedure Codes

ICD-10-PCS procedure codes:	Code Description
0DB64Z3	Excision of Stomach, Percutaneous Endoscopic Approach, Vertical
0D160ZA	Bypass Stomach to Jejunum, Open Approach
0D160ZB	Bypass Stomach to Ileum, Open Approach
0D164ZA	Bypass Stomach to Jejunum, Percutaneous Endoscopic Approach
0D164ZB	Bypass Stomach to Ileum, Percutaneous Endoscopic Approach
0D190ZB	Bypass Duodenum to Ileum, Open Approach
0D194ZB	Bypass Duodenum to Ileum, Percutaneous Endoscopic Approach
0DB60Z3	Excision of Stomach, Open Approach, Vertical
0DB60ZZ	Excision of Stomach, Open Approach
0DB80ZZ	Excision of Small Intestine, Open Approach
0DB90ZZ	Excision of Duodenum, Open Approach
0DBB0ZZ	Excision of Ileum, Open Approach
0DM60ZZ	Reattachment of Stomach, Open Approach
0DM64ZZ	Reattachment of Stomach, Percutaneous Endoscopic Approach
0DM80ZZ	Reattachment of Small Intestine, Open Approach
0DM84ZZ	Reattachment of Small Intestine, Percutaneous Endoscopic Approach
0DM90ZZ	Reattachment of Duodenum, Open Approach
0DM94ZZ	Reattachment of Duodenum, Percutaneous Endoscopic Approach
0DMA0ZZ	Reattachment of Jejunum, Open Approach
0DMA4ZZ	Reattachment of Jejunum, Percutaneous Endoscopic Approach
0DMB0ZZ	Reattachment of Ileum, Open Approach

0DMB4ZZ	Reattachment of Ileum, Percutaneous Endoscopic Approach
0DQ60ZZ	Repair Stomach, Open Approach
0DQ64ZZ	Repair Stomach, Percutaneous Endoscopic Approach
0DQ80ZZ	Repair Small Intestine, Open Approach
0DQ84ZZ	Repair Small Intestine, Percutaneous Endoscopic Approach
0DQ90ZZ	Repair Duodenum, Open Approach
0DQ94ZZ	Repair Duodenum, Percutaneous Endoscopic Approach
0DQA0ZZ	Repair Jejunum, Open Approach
0DQA4ZZ	Repair Jejunum, Percutaneous Endoscopic Approach
0DQB0ZZ	Repair Ileum, Open Approach
0DQB4ZZ	Repair Ileum, Percutaneous Endoscopic Approach
0DV60CZ	Restriction of Stomach with Extraluminal Device, Open Approach
0DV64CZ	Restriction of Stomach with Extraluminal Device, Percutaneous Endoscopic Approach

The following ICD Diagnosis Codes are considered medically necessary when submitted with the CPT and/or ICD Procedure Codes above if <u>medical necessity criteria</u> are met:

ICD-10 Diagnosis Codes

ICD-10-CM Diagnosis codes:	Code Description
E66.01	Morbid (severe) obesity due to excess calories
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) 50-59.9 , adult
Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.45	Body mass index (BMI) 70 or greater, adult

The following CPT codes are considered investigational for <u>Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:</u>

CPT Codes

CPT codes:	Code Description
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption

The following HCPCS codes are considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

HCPCS Codes

HCPCS codes:	Code Description
C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty, with esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components
C9785	Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components

Description

Bariatric Surgery

Bariatric surgery is performed to treat obesity and obesity-related comorbid conditions. The first treatment of obesity is dietary and lifestyle changes. Although this strategy may be effective in some patients, only a few individuals with obesity can reduce and control weight through diet and exercise. Most 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.

Summary

Description

Bariatric surgery is a treatment for class III 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.

Summary of Evidence

Adults with Class 3 Obesity

For individuals who are adults (18 years or older) with class 3 obesity (BMI $\geq$ 40kg/m^2) who are treated with bariatric surgery using open or laparoscopic gastric bypass using a Roux-en-Y, laparoscopic adjustable gastric banding, sleeve gastrectomy, or open or laparoscopic biliopancreatic bypass/diversion (ie, Scopinaro procedure) with duodenal switch, the evidence includes randomized controlled trials (RCTs), observational studies, and systematic reviews. Relevant outcomes are overall survival (OS), change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Evidence from nonrandomized comparative studies, case series, and meta-analyses of RCTs has consistently reported that bariatric surgery results in substantially greater weight loss than nonsurgical therapy. Data from the largest comparative study (the SOS study) found that bariatric surgery was associated with improvements in mortality, T2D, cardiovascular risk factors, and quality of life. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Adults with Class 2 Obesity

For individuals who are adults (18 years or older) with class 2 obesity (BMI $\geq$ 35 to 39.9ckg/m^2) who are treated with bariatric surgery using open or laparoscopic gastric bypass using a Roux-en-Y, laparoscopic adjustable gastric banding, sleeve gastrectomy, or open or laparoscopic biliopancreatic bypass/diversion (ie, Scopinaro procedure) with duodenal switch, the evidence includes RCTs, observational studies, and systematic reviews. Relevant outcomes are overall survival (OS), change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Evidence from nonrandomized comparative studies, case series, and meta-analyses of RCTs has consistently reported that bariatric surgery results in substantially greater weight loss than nonsurgical therapy. Data from the largest comparative study (the SOS study) found that bariatric surgery was associated with improvements in mortality, T2D, cardiovascular risk factors, and quality of life. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Adults with Class 1 Obesity and Type 2 Diabetes
For individuals who have Class 1 obesity (BMI ≥30 to 34.9 kg/m^2) and T2D who receive gastric bypass, SG, BPD, or LAGB, the evidence includes systematic reviews of RCTs and observational studies. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Systematic reviews of RCTs and observational studies have found that certain types of bariatric surgery are more efficacious than medical therapy as a treatment for T2D in adults with obesity, including those with a BMI between 30 and 34.9 kg/m^2. The greatest amount of evidence assesses gastric bypass, with some comparative studies on LAGB, LSG, and BPD. Systematic reviews have found significantly greater remission rates of diabetes, decrease in HbA1c levels, and decrease in BMI with bariatric surgery than with nonsurgical treatment. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Adults with a Body Mass Index <35 kg/m^2 Who Do Not Have Type 2 Diabetes
For individuals with a BMI <35 kg/m^2 who do not have type 2 diabetes who receive bariatric surgery, the evidence includes systematic reviews of RCTs and observational studies. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. A few small RCTs and case series have reported a loss of weight and improvements in comorbidities for this population. However, the evidence does not permit conclusions on the long-term risk-benefit ratio of bariatric surgery in this population. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Revision Bariatric Surgery
For individuals who are adults who receive revision bariatric surgery, the evidence includes systematic reviews, case series, and registry data. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. SSystematic reviews and case series have shown that patients receiving revision bariatric surgery experienced satisfactory weight loss and reduced comorbidities including GERD. Data from a multinational bariatric surgery database has found that corrective procedures following primary bariatric surgery are relatively uncommon but generally safe and efficacious. A large retrospective analysis found a serious complication rate of 7.2% for conversion to RYGB in 13,432 individuals and no difference in 30-day mortality compared to primary RYGB. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Adolescents with Obesity
For individuals who are adolescent children with obesity who receive gastric bypass, or LAGB, or SG, the evidence includes RCTs, observational studies, and systematic reviews. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Systematic reviews of studies on bariatric surgery in adolescents, who mainly received gastric bypass or LAGB or SG, found significant weight loss and reductions in comorbidity outcomes with bariatric surgery. For bariatric surgery in the adolescent population, although data are limited on some procedures, studies have generally reported that weight loss and reduction in risk factors for adolescents are similar to that for adults. Most experts and clinical practice guidelines have recommended that bariatric surgery in adolescents be reserved for individuals with severe comorbidities, or for individuals with a BMI greater than 50 kg/m^2. Also, greater consideration should be placed on the patient developmental stage, on the psychosocial aspects of obesity and surgery, and on ensuring that the patient can provide fully informed consent. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Preadolescent Children with Obesity
For individuals who are preadolescent children with obesity who receive bariatric surgery, there are no studies focused solely on this population. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Several studies of bariatric surgery in adolescents have also included children younger than 12 years old. A recent (2021) cohort study included 801 children ages 5 to 14 years in their total cohort of children and adolescents, and excess weight loss and comorbidity resolution were substantial and long-lasting without

safety concerns across all age groups. However, comparative studies are still lacking. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Hiatal Hernia Repair with Bariatric Surgery
For individuals with obesity and a preoperative diagnosis of a hiatal hernia who receive hiatal hernia repair with bariatric surgery, the evidence includes a systematic review, cohort studies, and case series. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. A systematic review found that hiatal hernia repair during SG was superior to SG alone for gastroesophageal reflux disease remission, but not de novo. Results from the cohort studies and case series have shown that, when a preoperative diagnosis of a hiatal hernia has been present, repairing the hiatal hernia during bariatric surgery resulted in fewer complications. However, the results are limited to individuals with a preoperative diagnosis. There was no evidence on the use of hiatal hernia repair when the hiatal hernia diagnosis is incidental. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
9/2024	Annual policy review. Policy updated with literature review through March 7, 2024. References added. Evidence review extensively pruned for clarity. ▪ Policy statements and evidence review indications revised to align with current obesity classification terminology and clinical practice guidelines. ▪ New medically necessary statement added for bariatric surgery in adults with Class 2 obesity and at least 1 obesity-related comorbid condition. ▪ Medically necessary statement on revision surgery clarified to include GERD as an indication for revision surgery. Effective 9/1/2024.
5/2024	Policy revised to include Bariatric Surgery in Adolescents (ages 12-18, who may not yet have completed bone growth) is considered medically necessary according to similar weight-based criteria used for adults. Bariatric Surgery Selection Criteria clarified to include: The individual has a BMI >30kg/m2 and has type 2 diabetes. One anastomosis gastric bypass added under investigational bariatric surgical procedures for the treatment of class III (BMI >40 kg/m2 or >35 kg/m2 with any of the comorbidities listed) obesity in adults who have failed weight loss by conservative measures. Effective 5/1/2024.
9/2023	Policy clarified to include prior authorization requests using Authorization Manager.
7/2023	Annual policy review. For completeness, medically necessary policy statement added for individuals who are diabetic and do not have class III obesity. Although no new evidence added for this population, evidence was previously determined to be sufficient. Additional minor editorial refinements made to policy statements with intent unchanged. Several guidelines updated and added. Effective 7/1/2023. Single Anastomosis Duodenal-ileal switch (SADI-s) and Apollo Device are investigational as a primary bariatric procedure or as a revision procedure. Coding Clarified. Effective 7/1/2023.
1/2023	Clarified coding information.
6/2022	Policy clarified. Policy statements on revision surgery to address perioperative or late complications of a bariatric procedure added.
6/2022	Prior authorization information clarified for PPO plans. Effective 6/1/2022.
4/2021	Annual policy review. Policy statement for adolescent bariatric surgery clarified due to updated weight-based criteria used for adults issued by the American Academy of Pediatrics.
1/2021	Policy clarified to include the following criteria: Has failed other non-surgical approaches to long-term weight loss. These approaches (i.e., diet and exercise plans, behavioral changes, etc.) and duration are up to the surgeon's discretion.

1/2021	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
4/2020	Annual policy review. Description, summary and references updated. Policy statements unchanged.
4/2019	Annual policy review. Description, summary and references updated. Policy statements unchanged.
3/2018	Annual policy review. New references added.
9/2017	Annual policy review. Investigational statement on endoscopic procedures rewritten for clarity; aspiration therapy device added to the investigational statement. Investigational statement on bariatric surgery in preadolescent children added. Effective 9/1/2017.
7/2016	Annual policy review. Single anastomosis duodenoileal bypass with sleeve gastrectomy added to investigational statement. Effective 7/1/2016.
3/2016	Policy statement removed: Medical management of obesity may be medically necessary including laboratory services and other diagnostic tests prescribed by the physician specialist, and nutritional counseling in accordance with the member's subscriber certificate. Clarified coding information. Effective 3/1/2016.
1/2016	Prior authorization information clarified. 1/1/2016.
10/2015	Clarified coding information.
6/2015	Medically necessary statements on revision bariatric surgery retired. Coding information clarified. Effective 6/1/2015.
3/2015	Annual policy review. New medically necessary and investigational indications described. Statement on bariatric surgery in individuals with BMI <35 changed from investigational to not medically necessary. Effective 3/1/2015.
10/2014	Language on Health Management Resources clarified.
9/2014	Clarified coding information. Surgical Management of Obesity Services Preauthorization Request Form transferred to #047.
6/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
3/2014	Annual policy review. Language added to policy statement on revision surgery to include complications of laparoscopic adjustable gastric banding. Effective 3/1/2014.
4/2013	Annual policy review. Changes to policy statement. Effective 4/1/2013.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
1/2012	Annual policy review. Changes to policy statements.
5/2011	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
11/2010	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
11/2010	Annual policy review. Changes to policy statements.
2/2010	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
11/2009	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
11/2009	Annual policy review. Changes to policy statements.
2/2009	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
11/2008	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
9/2008	Annual policy review. Changes to policy statements.
4/2008	Annual policy review. Changes to policy statements.
2/2008	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
5/2007	Annual policy review. BCBSA National medical policy review. Changes to policy statements.

2/2007	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
5/1996	New policy describing covered and non-covered indications. Effective 5/1996.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

References

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Endnotes

[1] Based on expert opinion