Bariatric Surgery
Clinical Coverage Criteria

Overview

Obesity is a major US health issue, with 39.8% of adults who are obese as of 2016. While surgery isn't for everyone, it does have good outcomes for many who are appropriate candidates. There are several procedures, each with advantages and disadvantages.

Policy

This Policy applies to the following Fallon Health products:
☒ Commercial
☒ Medicare Advantage
☒ MassHealth ACO
☒ NaviCare
☒ PACE

Prior authorization is required.

Fallon Health covers the following procedures:
- Open and laparoscopic Roux-en-Y gastric bypass (RYGBP)
- Gastric Reduction Duodenal Switch (BPD/GRDS)
- Laparoscopic adjustable gastric banding (LAGB)
- Laparoscopic sleeve gastrectomy (LSG)

Criteria for coverage:
- The member is an adult or adolescent who has failed other non-surgical approaches to long-term weight loss, 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 either:
- BMI ≥ 40, OR
- BMI ≥ 35 and at least one or more obesity-related co-morbidities such as type II diabetes (T2DM), at least Stage 1 Hypertension based on JNC-VII (SBP >140 and/or DBP >90) after combination pharmacotherapy, obesity related cardiomyopathy coronary artery disease, sleep apnea, obesity hypoventilation syndrome, Obesity related pulmonary hypertension non-alcoholic fatty liver disease, osteoarthritis, lipid abnormalities, or pseudotumor cerebri.

Bariatric surgery for preadolescent members is not covered.

Hiatal hernia repair at the time of bariatric surgery:
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).

Exclusions

- Bariatric surgery for preadolescent plan members is not covered.
- The following procedures are not covered:
  - Open adjustable gastric banding
  - Open sleeve gastrectomy
  - Open and laparoscopic vertical banded gastroplasty
  - Intestinal bypass surgery
  - Gastric balloon for treatment of obesity
  - Gastric bypass using a Billroth II type of anastomosis (mini-gastric bypass)
  - Biliopancreatic bypass without duodenal switch
  - Long limb gastric bypass (i.e., >150 cm)
  - Two-stage bariatric surgery procedures (e.g., sleeve gastrectomy as initial procedure followed by biliopancreatic diversion at a later time)
  - Laparoscopic gastric plication
  - Single anastomosis duodenoileal bypass with sleeve gastrectomy
  - Jejunoileal bypass
  - Horizontal gastric partitioning
  - Gastric wrapping
  - Gastric Electric Stimulation for the treatment of obesity (Gastric pacemaker)
  - any bariatric surgery performed as a cure for type 2 diabetes mellitus
  - Insertion of the StomaphyX™ device
  - Endoscopic gastroplasty
  - Use of an endoscopically placed duodenojejunal sleeve)
  - Aspiration therapy device

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

Code	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)
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
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption

References

1. Centers for Disease Control and Prevention, National Center for Health Statistics (NCHS) Table 21. Selected health conditions and risk factors, by age: United States, selected years 1988–1994 through 2015–2016. Available at: https://www.cdc.gov/nchs/data/hus/2018/021.pdf.
2. American Society for Metabolic and Bariatric Surgery (ASMBS). Bariatric Surgery Procedures. Available at: https://asmbs.org/patients/bariatric-surgery-procedures.
3. Medicare National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (100.1). Effective Date: 09/24/2013. Available at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.
4. MassHealth Guidelines for Medical Necessity Determination for Bariatric Surgery. Effective August 15, 2019. Available at: https://www.mass.gov/doc/bariatric-surgery/download.

Policy history

Origination date:	07/01/2014
Approval(s):	Technology Assessment Committee: 06/25/2014 (new modified policy to include Interqual and Fallon Health Criteria) 07/22/2015 (annual review no changes) 10/28/2015 (modifications to additional criteria) 10/26/2016 (annual review), 2/28/2018 (annual review), 02/27/2019 (annual review); 05/27/2019 (changed title: formerly Weight Loss Surgery; adopted Fallon Health criteria)

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.