MEDICAL POLICY

POLICY TITLE	METABOLIC AND BARIATRIC SURGERY
POLICY NUMBER	MP 1.015

Effective Date:	1/1/2024

I. POLICY

Metabolic and Bariatric Surgery for Morbid Obesity

The following metabolic and bariatric surgery (MBS) procedures may be considered **medically necessary** when performed by surgeons who are adequately trained and experienced in the specific techniques used and when the surgery is part of a comprehensive MBS program:

- Open gastric bypass using a Roux-en-Y anastomosis; **or**
- Laparoscopic gastric bypass using a Roux-en-Y anastomosis; **or**
- Laparoscopic adjustable gastric banding; **or**
- Sleeve gastrectomy; **or**
- Open or laparoscopic biliopancreatic diversion (i.e., the Scopinaro procedure) with duodenal switch.
- Single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S)

Metabolic and Bariatric Surgery in Adults

The above MBS procedures may be considered **medically necessary** for the treatment of morbid obesity adults in individuals who have met **ALL** of the following:

- Patient is at least 18 years of age (see adolescent and child criteria below); **and**
- The requesting physician documents that the patient affirms they have not smoked (including e-cigarettes) or vaped tobacco, marijuana, or other substances within the six (6) weeks prior to the procedure and they plan to refrain from tobacco use following MBS; **and**
- Patient is not currently pregnant and has been counseled to avoid pregnancy for 12 to 18 months following MBS; **and**
- Patient has been unable to achieve sustainable weight loss despite active use of conservative measures. An attestation from the member's primary care provider or complete history by the MBS team will be considered adequate documentation of a patient's attempt to lose weight using more conservative measures.
- The patient meets **one** (1) of the following BMI categories:
  - BMI > 35 kg/m2
  - BMI ≥ 30 kg/m2 with at least one of the following:
    - Asthma; **or**
    - Bone and joint diseases; **or**
    - Cardiovascular disease (e.g. coronary artery disease, heart failure, atrial fibrillation); **or**

        - Chronic kidney disease; **or**
        - Dyslipidemia; **or**
        - Fatty liver disease and nonalcoholic steatohepatitis; **or**
        - Gastroesophageal reflux disease (GERD); **or**
        - Hypertension; **or**
        - Infertility; **or**
        - Obstructive sleep apnea; **or**
        - Polycystic ovarian syndrome; **or**
        - Pseudotumor cerebri; **or**
        - Type 2 diabetes mellitus (T2D)
- Patient must successfully participate in a multi-disciplinary pre-operative MBS program prior to surgery. The program should follow the guidelines developed by the American Society of Metabolic and Bariatric Surgery. It must be well documented and include **ALL** of the following elements:
    - A thorough medical history and physical examination; **and**
    - An evaluation with a mental health professional that
        - identifies potential contraindications to surgical intervention, such as substance abuse or poorly controlled psychiatric illness; **and**
        - identifies interventions that can enhance long-term weight management; **and**
        - assesses the patient's ability to comply with treatment; **and**
        - documents the recommendation for surgery
        - A behavior modification program; **and**
        - Consultation with a dietician or nutritionist; **and**
        - An exercise program; **and**
        - A reduced-calorie diet that is supervised by a physician, dietician, or nutritionist that demonstrates the patient's ability to comply with post-operative diet; **and**
        - A documented post-operative care plan, which demonstrates plans for continued involvement in the multi-disciplinary comprehensive bariatric surgery program.
- Patient attends all required appointments during participation in the multi-disciplinary pre-operative MBS program.

Metabolic and Bariatric Surgery in Adolescents and Children

Metabolic and Bariatric surgery may be considered **medically necessary** for the treatment of morbid obesity in adolescents and children who have met **ALL** of the following:

- The patient meets one (1) of the following BMI categories :
    - BMI >140% of the 95th percentile (class III obesity/BMI ≥ 40)
    - BMI >120% of the 95th percentile (class II obesity/BMI ≥ 35) with one of the following obesity related comorbidities:
        - Cardiovascular disease; **or**
        - Gastroesophageal reflux disease (GERD); or
        - Hypertension; or
        - Hyperlipidemia refractory to diet and maximum doses of lipid lowering agents; or
        - Nonalcoholic fatty liver disease (NAFLD) **or**
        - Type 2 diabetes; **or**

        - Obstructive sleep apnea that requires positive airway pressure; **or**
        - Obesity hypoventilation syndrome (OHS); **or**
        - Pseudotumor cerebri; **or**
        - Severe arthropathy of spine or weight bearing joints (ie Slipped capital femoral epiphysis, Blount disease)
- Patient must successfully participate in a multi-disciplinary pre-operative MBS program. The program must be well documented and include **all** of the following elements:
    - A thorough medical history and physical examination; **and**
    - An evaluation with a mental health professional that assesses the patient and the patients' family's ability to comply with treatment and documents the recommendation for surgery; **and**
    - A behavior modification program; **and**
    - Consultation with a dietician or nutritionist; **and**
    - An exercise program; **and**
    - A reduced-calorie diet that is supervised by a physician, dietician, or nutritionist that demonstrates the patient's ability to comply with post-operative diet; **and**
    - A documented post-operative care plan, which demonstrates plans for continued involvement in the multi-disciplinary comprehensive MBS program.
- Patient attends all required appointments during participation in the multi-disciplinary pre-operative MBS program.

Contraindications for MBS in adolescents and children include:

- A medically correctable cause of obesity
- An ongoing substance abuse within the preceding year
- A medical, psychiatric, psychosocial or cognitive condition that prevents adherence to postoperative dietary and medication regimens
- Current or planned pregnancy within 12 to 18 months of the procedure

Greater consideration should be given to developmental, psychosocial and informed consent issues (see Policy Guidelines section). In addition, any devices used for bariatric surgery must be used in accordance with the U.S. Food and Drug Administration (FDA) approved indications.

Revision Metabolic and Bariatric Surgery

Revision surgery to address perioperative or late complications of an MBS procedure may be considered **medically necessary**. These include, but are not limited to, weight regain, GERD, staple-line failure, obstruction, stricture, non-absorption 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 surgery may be indicated for weight regain when initial criteria is met (see Policy Guidelines).

Revision of a primary MBS procedure that has failed due to dilation of the gastric pouch, dilation of the gastric sleeve, or dilation proximal to an adjustable gastric band (documented by upper gastrointestinal examination or endoscopy) may be considered **medically necessary** if the initial procedure was successful in inducing weight loss prior to the occurrence of the dilation, and the patient has been compliant with a prescribed nutrition and exercise program.

Metabolic and Bariatric Surgery in Patients with a BMI < 30 kg/m^2

Metabolic and bariatric surgery is considered **not medically necessary** for patients with a BMI less than 30 kg/m^2**.**

The following MBS procedures are considered **investigational** for the treatment of morbid obesity in adults who have failed weight loss by conservative measures:

- Vertical-banded gastroplasty
- Gastric bypass using a Billroth II type of anastomosis (mini-gastric bypass)
- Biliopancreatic bypass without duodenal switch
- Long-limb gastric bypass procedure (i.e., greater than 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

The following endoscopic procedures are considered **investigational** as a primary MBS procedure or as a revision procedure (i.e., to treat weight gain after MBS surgery to remedy large gastric stoma or large gastric pouches):

- Insertion of the StomaphyX™ device
- Endoscopic gastroplasty
- Use of an endoscopically placed duodenojejunal sleeve
- Intragastric balloons
- Aspiration therapy device.

Concomitant Hiatal Hernia Repair with Metabolic and Bariatric Surgery

Repair of a hiatal hernia at the time of MBS surgery may be considered **medically necessary** for patients who have a preoperatively-diagnosed hiatal hernia with indications for surgical repair (see Policy Guidelines).

Repair of a hiatal hernia that is diagnosed at the time of MBS, or repair of a preoperatively diagnosed hiatal hernia in patients who do not have indications for surgical repair, is considered **investigational**.

There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with the above **investigational** procedures.

POLICY GUIDELINES

Patients should have documented failure to respond to conservative measures for weight reduction prior to consideration of MBS, and these attempts should be reviewed by the practitioner prior to seeking approval for the surgical procedure. As a result, some centers require active participation in a formal weight reduction program that includes frequent documentation of weight, dietary regimen, and exercise. However, there is a lack of evidence on

the optimal timing, intensity, and duration of nonsurgical attempts at weight loss, and whether a medical weight loss program immediately preceding surgery improves outcomes.

Patient Selection Criteria

As per The American Society of Metabolic and Bariatric Surgery (ASMBS), in the Asian population the prevalence of diabetes and cardiovascular disease is higher at a lower BMI than in the non-Asian population. Thus, BMI risk zones should be adjusted to define obesity at a BMI threshold of 25–27.5 kg/m2 in this population. Therefore, in certain populations access to MBS should not be denied solely based on traditional BMI thresholds.

MBS in the High Risk Patient

There is no consensus concerning the best procedure for individuals with especially high BMI, but the efficacy and safety of MBS have been demonstrated in this population In general, mortality risk increases with increasing BMI, and BMI >50 kg/m^2 has been implicated in increasing surgical risk in older studies. Individuals with BMI >60 kg/m^2 are considered to be at especially high risk for surgery since these patients have greater obesity-associated disease burden and more challenging surgical anatomy, resulting in longer operative times, higher rates of perioperative morbidity, and longer hospital lengths of stay in some studies. Others, however, failed to demonstrate a significant difference in perioperative complications, length of stay, 30-day mortality, or long-term outcomes after MBS when individuals with BMI >60 kg/ m2 were compared with those with BMI <60 kg/m^2. Furthermore, studies have shown that MBS can be performed safely in patients with BMI >70 kg/m^2. Therefore, MBS should be considered as a preferred method to achieve clinically significant weight loss in patients with extreme BMI.

Hiatal Hernia Repair Guidelines

The Society of American Gastrointestinal and Endoscopic Surgeons has issued evidence-based guidelines for the management of hiatal hernia (Kohn et al, 2013). The authors note that the general methodologic quality of available studies is low. 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).

Abdominal Wall Hernia Repair Guidelines

The American Society of Metabolic and Bariatric Surgery states that while the timing of MBS relative to hernia repair remains controversial, evidence suggests that patients with large, chronic abdominal wall hernia may benefit from significant weight loss initially as staged procedure to

definitive hernia repair. Thus, in patients with severe obesity and an abdominal wall hernia requiring elective repair, MBS should be considered first to induce significant weight loss, and consequently reduce the rate of complications associated with hernia repair and increase durability of the repair.

Cross-references:

MP 2.045 Diagnosis and Medical Management of Obstructive Sleep Apnea
MP 2.053 Surgical Treatments for Gastroesophageal Reflux Disease
MP 2.069 Gastric Electric Stimulation

II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital BlueCross and subject to benefit variations as discussed in Section VI. Please see additional information below.

FEP PPO - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:
https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

III. DESCRIPTION/BACKGROUND

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Bariatric Surgery

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

Metabolic and Bariatric surgery is performed to treat morbid (clinically severe) obesity. Morbid obesity is defined as a BMI greater than 40 kg/m^2 or a BMI greater than 35 kg/m^2 with associated complications including, but not limited to, diabetes, hypertension, or obstructive sleep apnea. Morbid obesity results in a very high risk for weight-related complications, such as diabetes, hypertension, obstructive sleep apnea, and various types of cancers (for men: colon, rectal, prostate; for women: breast, uterine, ovarian), and a shortened life span. A morbidly obese man at age 20 can expect to live 13 fewer years than his counterpart with a normal BMI, which equates to a 22% reduction in life expectancy.

The first treatment of morbid obesity is dietary and lifestyle changes. Although this strategy may be effective in some patients, only a few morbidly obese individuals can reduce and control weight through diet and exercise. 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.
Resolution (cure) or improvement of type 2 diabetes after bariatric surgery and observations that glycemic control may improve immediately after surgery before a significant amount of

weight is lost have promoted interest in a surgical approach to treatment of type 2 diabetes. The various surgical procedures have different effects, and gastrointestinal rearrangement seems to confer additional antidiabetic benefits independent of weight loss and caloric restriction. The precise mechanisms are not clear, and multiple mechanisms may be involved. Gastrointestinal peptides, e.g., glucagon-like peptide-1, glucose-dependent insulinotropic peptide, and peptide YY, are secreted in response to contact with unabsorbed nutrients and by vagally mediated parasympathetic neural mechanisms. Glucagon-like peptide-1 is secreted by the L cells of the distal ileum in response to ingested nutrients and acts on pancreatic islets to augment glucose-dependent insulin secretion. It also slows gastric emptying, which delays digestion, blunts postprandial glycemia, and acts on the central nervous system to induce satiety and decrease food intake. Other effects may improve insulin sensitivity. Glucose-dependent insulinotropic peptide acts on pancreatic beta cells to increase insulin secretion through the same mechanisms as glucagon-like peptide-1, although it is less potent. Peptide YY is also secreted by the L cells of the distal intestine and increases satiety and delays gastric emptying.

Types of Bariatric Surgery Procedures

The following summarizes the most common types of bariatric surgery procedures.

Open Gastric Bypass

The original gastric bypass surgeries were based on the observation that postgastrectomy patients tended to lose weight. The current procedure (CPT code 43846) involves both a restrictive and a malabsorptive component, with horizontal or vertical partition of the stomach performed in association with a Roux-en-Y procedure (i.e., a gastrojejunal anastomosis). Thus, the flow of food bypasses the duodenum and proximal small bowel. The procedure may also be associated with an unpleasant “dumping syndrome”, in which a large osmotic load delivered directly to the jejunum from the stomach produces abdominal pain and/or vomiting. The dumping syndrome may further reduce intake, particularly in “sweets eaters”. Surgical complications include leakage and operative margin ulceration at the anastomotic site. Because the normal flow of food is disrupted, there are more metabolic complications than with other gastric restrictive procedures, including iron deficiency anemia, vitamin B_{12} deficiency, and hypocalcemia, all of which can be corrected by oral supplementation. Another concern is the ability to evaluate the blind bypassed portion of the stomach. Gastric bypass may be performed with either an open or laparoscopic technique.

Note: In 2005, the CPT code 43846 was revised to indicate that the short limb must be 150 cm or less, compared with the previous 100 cm. This change reflects the common practice in which the alimentary (i.e., jejunal limb) of a gastric bypass has been lengthened to 150 cm. This length also serves to distinguish a standard gastric bypass with a very long, or very, very long gastric bypass, as discussed further here.

Laparoscopic Gastric Bypass

CPT code 43644 was introduced in 2005 and described the same procedure as open gastric bypass (CPT code 43846), but performed laparoscopically.

Adjustable Gastric Banding

Adjustable gastric banding (CPT code 43770) involves placing a gastric band around the exterior of the stomach. The band is attached to a reservoir implanted subcutaneously in the rectus sheath. Injecting the reservoir with saline will alter the diameter of the gastric band; therefore, the rate-limiting stoma in the stomach can be progressively narrowed to induce greater weight loss, or expanded if complications develop. Because the stomach is not entered, the surgery and any revisions, if necessary, are relatively simple.

Complications include slippage of the external band or band erosion through the gastric wall. Adjustable gastric banding has been widely used in Europe. Two banding devices are approved by the U.S. Food and Drug Administration (FDA) for marketing in the United States. The first to receive FDA approval was the LAP-BAND (original applicant, Allergan, BioEnterics, Carpinteria, CA; now Apollo Endosurgery, Austin, TX). The labeled indications for this device are as follows:

> "The LAP-BAND® system is indicated for use in weight reduction for severely obese patients with a BMI of at least 40 or a BMI of at least 35 with one or more severe comorbid conditions, or those who are 100 lb or more over their estimated ideal weight according to the 1983 Metropolitan Life Insurance Tables (use the midpoint for medium frame). It is indicated for use only in severely obese adult patients who have failed more conservative weight-reduction alternatives, such as supervised diet, exercise and behavior modification programs. Patients who elect to have this surgery must make the commitment to accept significant changes in their eating habits for the rest of their lives."

In 2011, FDA-labelled indications for the LAP-BAND were expanded to include patients with a BMI from 30 to 34 kg/m^2 with at least one (1) obesity-related comorbid condition.

The second adjustable gastric banding device approved by FDA through the premarket approval process is the REALIZE® model (Ethicon Endo-Surgery, Cincinnati, OH). Labeled indications for this device are:

> The [REALIZE] device is indicated for weight reduction for morbidly obese patients and is indicated for individuals with a BMI of at least 40 kg/m^2, or a BMI of at least 35 kg/m^2 with one or more comorbid conditions. The Band is indicated for use only in morbidly obese adult patients who have failed more conservative weight-reduction alternatives, such as supervised diet, exercise, and behavior modification programs.

Sleeve Gastrectomy

A sleeve gastrectomy (CPT code 43775) is an alternative approach to gastrectomy that can be performed on its own or in combination with malabsorptive procedures (most commonly biliopancreatic diversion [BPD] with duodenal switch). In this procedure, the greater curvature of the stomach is resected from the angle of His to the distal antrum, resulting in a stomach remnant shaped like a tube or sleeve. The pyloric sphincter is preserved, resulting in a more physiologic transit of food from the stomach to the duodenum and avoiding the dumping syndrome (overly rapid transport of food through stomach into intestines) seen with distal gastrectomy. This procedure is relatively simple to perform and can be done as an open or laparoscopic procedure. Some surgeons have proposed the sleeve gastrectomy as the first in a

2-stage procedure for very high risk patients. Weight loss following sleeve gastrectomy may improve a patient's overall medical status and, thus, reduce the risk of a subsequent more extensive malabsorptive procedure (e.g., BPD).

Biliopancreatic Bypass Diversion

The BPD procedure (also known as the Scopinaro procedure; CPT code 43847) developed and used extensively in Italy, was designed to address drawbacks of the original intestinal bypass procedures that have been abandoned due to unacceptable metabolic complications. Many complications were thought to be related to bacterial overgrowth and toxin production in the blind, bypassed segment. In contrast, BPD consists of a subtotal gastrectomy and diversion of the biliopancreatic juices into the distal ileum by a long Roux-en-Y procedure. The procedure consists of the following components:

a. A distal gastrectomy induces a temporary early satiety and/or the dumping syndrome in the early postoperative period, both of which limit food intake.
b. A 200-cm long alimentary tract consists of 200 cm of ileum connecting the stomach to a common distal segment.
c. A 300- to 400-cm biliary tract connects the duodenum, jejunum, and remaining ileum to the common distal segment.
d. A 50- to 100-cm common tract is where food from the alimentary tract mixes with biliopancreatic juices from the biliary tract. Food digestion and absorption, particularly of fats and starches, are therefore limited to this small segment of bowel, creating selective malabsorption. The length of the common segment will influence the degree of malabsorption.

Because of the high incidence of cholelithiasis associated with the procedure, patients typically undergo an associated cholecystectomy.

Many potential metabolic complications are related to BPD, including, most prominently, iron deficiency anemia, protein malnutrition, hypocalcemia, and bone demineralization. Protein malnutrition may require treatment with total parenteral nutrition. In addition, several case reports have noted liver failure resulting in death or liver transplant.

Biliopancreatic Bypass Diversion with Duodenal Switch

CPT code 43845, which specifically identifies the duodenal switch procedure, was introduced in 2005. The duodenal switch procedure is a variant of the BPD previously described. In this procedure, instead of performing a distal gastrectomy, a sleeve gastrectomy is performed along the vertical axis of the stomach. This approach preserves the pylorus and initial segment of the duodenum, which is then anastomosed to a segment of the ileum, similar to the BPD, to create the alimentary limb. Preservation of the pyloric sphincter is intended to ameliorate the dumping syndrome and decrease the incidence of ulcers at the duodenoileal anastomosis by providing a more physiologic transfer of stomach contents to the duodenum. The sleeve gastrectomy also decreases the volume of the stomach and decreases the parietal cell mass. However, the basic principle of the procedure is similar to that of the BPD, i.e., producing selective malabsorption by limiting the food digestion and absorption to a short common ileal segment.

Vertical-Banded Gastroplasty

Vertical-banded gastroplasty (VBG; CPT code 43842) was formerly one of the most common gastric restrictive procedures performed in the United States, but has now been replaced by other restrictive procedures due to high rates of revisions and reoperations. In this procedure, the stomach is segmented along its vertical axis. In order to create a durable reinforced and rate-limiting stoma at the distal end of the pouch, a plug of stomach is removed, and a propylene collar is placed through this hole and then stapled to itself. Because the normal flow of food is preserved, metabolic complications are uncommon. Complications include esophageal reflux, dilation, or obstruction of the stoma, with the latter two requiring reoperation. Dilation of the stoma is a common reason for weight regain. VBG may be performed using an open or laparoscopic approach.

Long-Limb Gastric Bypass (i.e., greater than 150 cm)

Variations of gastric bypass procedures have been described, consisting primarily of long-limb Roux-en-Y procedures (CPT code 43847), which vary in the length of the alimentary and common limbs. For example, the stomach may be divided with a long segment of the jejunum (instead of ileum) anastomosed to the proximal gastric stump, creating the alimentary limb. The remaining pancreaticobiliary limb, consisting of stomach remnant, duodenum, and length of proximal jejunum, is then anastomosed to the ileum, creating a common limb of variable length in which the ingested food mixes with the pancreaticobiliary juices. While the long alimentary limb permits absorption of most nutrients, the short common limb primarily limits absorption of fats. The stomach may be bypassed in a variety of ways (e.g., resection or stapling along the horizontal or vertical axis). Unlike the traditional gastric bypass, which is a gastric restrictive procedure, these very long-limb Roux-en-Y gastric bypasses combine gastric restriction with some element of malabsorptive procedure, depending on the location of the anastomoses. Note that CPT code for gastric bypass (43846) explicitly describes a short limb (less than150 cm) Roux-en-Y gastroenterostomy, and thus would not apply to long-limb gastric bypass.

Laparoscopic Malabsorptive Procedure

CPT code 43645 was introduced in 2005 to specifically describe a laparoscopic malabsorptive procedure. However, the code does not specifically describe any specific malabsorptive procedure.

Single-Anastomosis Duodenal-ileal bypass with sleeve gastrectomy (SADI-S)

CPT code 43659 (NOC code) can be used to signify this variation of the classic duodenal switch approach. In this procedure, the transected duodenum is anastomosed to a loop of distal small bowel as opposed to the Roux-en-Y configuration. This results in only one anastomosis.

Weight Loss Outcomes

There is no uniform standard for reporting results of weight loss or for describing a successful procedure. Common methods of reporting the amount of body weight loss are percent of ideal body weight achieved or percent of excess body weight (EBW) loss, with the latter most commonly reported. Excess body weight is defined as actual weight minus “ideal weight” and

"ideal weight" and is based on 1983 Metropolitan Life Insurance height-weight tables for "medium frame."

These two (2) methods are generally preferred over the absolute amount of weight loss, because they reflect the ultimate goal of surgery: to reduce weight into a range that minimizes obesity-related morbidity. Obviously, an increasing degree of obesity will require a greater amount of weight loss to achieve these target goals. There are different definitions of successful outcomes, but a successful procedure is often considered one in which at least 50% of EBW is lost, or when the patient returns to within 30% of ideal body weight. The results may also be expressed as the percentage of patients losing at least 50% of EBW. Table 1 summarizes the variations in reporting weight loss outcomes.

Table 1. Weight Loss Outcomes

Outcome Measures	Definition	Clinical Significance
Decrease in weight	Absolute difference in weight pre- and post-treatment	Unclear relation to outcomes, especially in morbidly obese
Decrease in BMI	Absolute difference in BMI pre- and post-treatment	May be clinically significant if change in BMI clearly leads to change in risk category
Percent EBW loss	Amount of weight loss divided by EBW	Has anchor to help frame clinical significance; unclear threshold for clinical significance
Percent patients losing greater than 50% EBW	No. patients losing greater than 50% EBW divided by total patients	Additional advantage to help framing on per patient basis. Threshold for significance (greater than 50%) arbitrary.
Percent ideal body weight	Final weight divided by ideal body weight	Has anchor to help frame, clinical significance; unclear threshold for clinical significance

BMI: body mass index, EBW: excess body weight

Durability of Weight Loss

Weight change (i.e., gain or loss) at yearly intervals is often reported. Weight loss at one (1) year is considered the minimum length of time for evaluating these procedures; weight loss at three (3) to five (5) years is considered an intermediate time period for evaluating weight loss; and weight loss at five (5) to ten (10) years or more is considered to represent long-term weight loss following bariatric surgery.

Short-Term Complications (Operative and Perioperative Complications less than 30 Days)

In general, the incidence of operative and perioperative complications is increased in obese patients, particularly in thromboembolism and wound healing. Other perioperative complications

include anastomotic leaks, bleeding, bowel obstruction, and cardiopulmonary complications (e.g., pneumonia, myocardial infarction).

Reoperation Rate

Reoperation may be required to either take down or revise the original procedure. Reoperation may be particularly common in VBG due to pouch dilation.

Long-Term Complications (Metabolic Adverse Events, Nutritional Deficiencies)

Metabolic adverse events are of particular concern in malabsorptive procedures. Other long-term complications include anastomotic ulcers, esophagitis, and procedure-specific complications such as band erosion or migration for gastric-banding surgeries.

Improved Health Outcomes in Terms of Weight-Related Comorbidities

Aside from psychosocial concerns, which may be considerable, one motivation for bariatric surgery is to decrease the incidence of complications of obesity, such as diabetes, cardiovascular risk factors (i.e., increased cholesterol, hypertension), obstructive sleep apnea, or arthritis. Unfortunately, these final health outcomes are not consistently reported.

Regulatory Status

Forms of bariatric surgery performed without specific implantable devices are surgical procedures and, as such, is not subject to regulation by the FDA.

Table 2 shows forms of bariatric surgery with implantable devices approved by FDA through the premarket approval process.

Table 2: FDA-Approved Bariatric Surgery Devices

Device	Manufacturer	PMA Date	Labeled Indications
Obalon™ intra gastric balloon system	Obalon Therapeutics, Inc.	Sept 2016	For use in obese adults (BMI, 30 to 40 kg/m^2) who have failed weight reduction with diet and exercise, and have no contraindications. Maximum placement time is 6 mo. Balloon is encased in a capsule. The capsule is swallowed and begins to dissolve after exposure to fluids in the stomach. After verification of capsule placement in the stomach, the balloon is filled with a gas mixture. Up to 3 balloons can be used during the 6 mo treatment period.
AspireAssist System ®	Aspire Bariatrics	Jin 2016	For long-term use in conjunction with lifestyle therapy and continuous medical monitoring in obese adults less than 22 y, with a BMI of 35.0 to 55.0 kg/m^2 and no contraindications to

			the procedure who have failed to achieve and maintain weight loss with nonsurgical weight loss therapy
ORBERA ® intragastric balloon system	Apollo Endosurgery	Aug 2015	For use in obese adults (BMI, 30-40 kg/m²) who have failed weight reduction with diet and exercise, and have no contraindications. Maximum placement time is 6 mo. Balloon placed endoscopically and inflated with saline.
LAP-BAND® Adjustable Gastric Banding System	Apollo Endosurgery (original applicant: Allergan)	Apr 2010	For use in weight reduction for severely obese adults with BMI of at least 40 kg/m2 or a BMI of at least 30 kg/m2 with ≥1 severe comorbid conditions who have failed more conservative weight-reduction alternatives (eg, supervised diet, exercise, behavior modification programs).
REALIZE ® Adjustable Gastric Band	Ethicon Endosurgery	Nov 2007	For use in weight reduction for morbidly, obese patients and for individuals with BMI of at least 40 kg/m², or a BMI of at least 35 kg/m² with greater than or equal to 1 comorbid conditions, or those who are ≥45.4 kg over their estimated ideal weight. Indicated for use only in morbidly obese adults who have failed more conservative weight-reduction alternatives (e.g. supervised diet, exercise, behavior modification programs).

BMI: body mass index: FDA: Food and Drug Administration, PMA: premarket approval.

In February 2017, the FDA issued a letter to health care providers discussing the potential risks with liquid-filled intragastric balloons in response to reports of 2 types of adverse events related to the balloons. Several dozen reports concerned spontaneous overinflation of the balloons, which caused pain, swelling, and vomiting. The second set of adverse event reports indicated that acute pancreatitis developed in several patients due to compression of gastrointestinal structures. These reports involved both ReShape (no longer marketed in the US) and ORBERA brands. The adverse events may require premature removal of the balloons.

In August 2017, the FDA issued a second letter to health care providers informing them of 5 unanticipated deaths occurring from 2016 through the time of the letter, due to intragastric balloons. The FDA recommended close monitoring of patients receiving these devices. In June 2018, the FDA reported that, since 2016, a total of 12 deaths occurred in patients with liquid-filled intragastric balloons worldwide; 7 of these deaths were in patients in the U.S.

In April 2020, the FDA provided an update on risks and continued to recommend that healthcare providers "instruct patients about the symptoms of life-threatening complications such as balloon deflation, gastrointestinal obstruction, and gastric and esophageal perforation and monitor patients closely during the entire duration of treatment for potential complications,

including acute pancreatitis, spontaneous hyperinflation, and other potentially life-threatening complications."

IV. RATIONALE

Summary of Evidence

Adults with Morbid Obesity

For individuals who are adults with morbid obesity who receive gastric bypass, the evidence includes randomized controlled trials (RCTs), observational studies, and systematic reviews. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Technology Evaluation Center (TEC) Assessments and other systematic reviews of RCTs and observational studies found that gastric bypass improves health outcomes, including weight loss and remission of type 2 diabetes (T2D). A TEC Assessment found similar weight loss with open and laparoscopic gastric bypass. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are adults with morbid obesity who receive laparoscopic adjustable gastric banding (LAGB), the evidence includes RCTs, observational studies, and systematic reviews. Relevant outcomes are overall survival, 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 LAGB is a reasonable alternative to gastric bypass. There is less weight loss with LAGB than with gastric bypass, but LABG is less invasive and is associated with fewer serious adverse events. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are adults with morbid obesity who receive sleeve gastrectomy (SG), the evidence includes RCTs, observational studies (evaluating SG alone and comparing SG with gastric bypass), and systematic reviews. Relevant outcomes are overall survival, 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 SG results in substantial weight loss and that this weight loss is durable for at least 5 years. A meta-analysis found that short-term weight loss was similar after SG compared with gastric bypass. Long-term weight loss was greater after gastric bypass, but SG is associated with fewer AEs. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are adults with morbid obesity who receive biliopancreatic diversion (BPD) with duodenal switch, the evidence includes nonrandomized comparative studies, observational studies and a systematic review. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Non-randomized comparative studies found significantly higher weight loss after BPD with duodenal switch compared with gastric bypass at 1 year. A large case series found sustained weight loss after 7 years. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are adults with morbid obesity who receive BPD without duodenal switch, the evidence includes observational studies and systematic reviews. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. A TEC Assessment reviewed the available observational studies and concluded that weight loss was similar after BPD without duodenal switch or gastric bypass. However concerns have been raised about complications associated with BPD without duodenal switch, especially long-term nutritional and vitamin deficiencies. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are adults with morbid obesity who receive vertical-banded gastroplasty (VBG), the evidence includes observational studies and systematic reviews. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. A TEC Assessment identified 8 nonrandomized comparative studies evaluating VBG and these studies found that weight loss was significantly greater with open gastric bypass. Moreover, VBG has relatively high rates of complications, revisions, and reoperations. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are adults with morbid obesity who receive 2-stage bariatric surgery procedures, the evidence includes a small RCT, observational studies and case series. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. There is a lack of evidence that 2-stage bariatric procedures improve outcomes compared with 1-stage procedures. The small RCT compared intragastric balloon (IGB) plus gastric bypass with the standard of care plus gastric bypass and did not detect a difference in weight loss at 6 months postsurgery. Case series have shown relatively high complication rates in 2-stage procedures, and patients are at risk of complications in both stages. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are adults with morbid obesity who receive laparoscopic gastric plication, the evidence includes an RCT, an observational study, and systematic reviews. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. A 2021 systematic review demonstrated that laparoscopic SG is superior to laparoscopic greater curvature gastric plication with regard to providing effective weight loss through 24 months; statistical significance was not reached at 36 months. The difference in the improvement of comorbidities and risk of major complications or mortality did not reach statistical significance between groups. One additional RCT compared endoscopic gastric plication with a sham procedure, reporting 1-year follow-up results in favor of the intervention. Additional comparative studies and RCTs with longer follow-up are needed to permit conclusions about the safety and efficacy of laparoscopic gastric plication. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are adults with morbid obesity who receive single anastomosis duodeno-ileal bypass with SG (SADI-S), the evidence includes a systematic review of observational studies and case series. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. A systematic review of 12 observational studies concluded that SADI-S was associated with promising weight loss and comorbidity resolution. A comparative chart review found that patients without diabetes experienced significantly better weight loss and lipid profiles with SADI-S than with RYGB and patients who had diabetes experienced significantly higher rates of remission with SADI-S than with Roux-en-y gastric bypass (RYGB) and patients who had diabetes experienced significantly higher rates of remission with SADI-S than with RYGB. Comparative studies and especially RCTs are needed to permit conclusions about the safety and efficacy of SADI-S. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome. However this procedure is supported by the American Society for Metabolic and Bariatric Surgery.

For individuals who are adults with morbid obesity who receive duodenojejunal sleeve, the evidence includes RCTs and systematic reviews. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. A systematic review of duodenojejunal sleeves included 5 RCTs and found significantly greater short-term weight loss (12-24 weeks) with the sleeves compared with medical therapy. There was no significant difference in symptoms associated with diabetes. All RCTs were small and judged by systematic reviewers to be at high risk of bias. High-quality comparative studies are needed to permit conclusions on the safety and efficacy of the procedure. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are adults with morbid obesity who receive intragastric balloon (IGB) devices, the evidence includes RCTs, systematic reviews, and case series. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. RCTs assessing the 2 IGB devices approved by the FDA have found significantly greater weight loss with IGB than with sham treatment or lifestyle therapy alone after 6 months (maximum length of device use). Some adverse events were reported, mainly related to accommodation of the balloon in the stomach; in a minority of cases, these adverse events were severe. One RCT followed patients for an additional 6 months after IGB removal and found sustained weight loss. There are limited data on the durability of weight loss in the long-term. Comparative data are lacking. A large case series found that patients gradually regained weight over time. Moreover, it is unclear how 6 months of IGB use would fit into a long-term weight loss and maintenance intervention. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are adults with morbid obesity who receive an aspiration therapy device, the evidence includes an RCT and case series. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. The RCT found significantly greater weight loss with aspiration

therapy than lifestyle therapy at 1 year. Forty of 58 patients (69%) achieved at least 10% total weight loss at 4 years or at time of study withdrawal; however, only 15/111 initial aspiration therapy patients completed the study through 4 years. In addition to a high degree of missing data, the Pivotal Aspiration Therapy with Adjusted Lifestyle (PATHWAY) study noted a potentially large number of adverse events related to A-tube malfunction, an element of the therapy which is expected to require replacement within approximately 3.5 years postgastrostomy in 50% of cases. The impact of this on health outcomes compared to existing surgical approaches is unknown. One small case series reported on 15 patients at 2 years. The total amount of data on aspiration therapy remains limited and additional studies are needed before conclusions can be drawn about the effects of treatment on weight loss, metabolism, safety, nutrition, and long-term durability of treatment. 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 with morbid obesity and failed bariatric surgery who receive revision bariatric surgery, the evidence includes case series and registry data. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Systematic reviews and case series have shown that patients receiving revision bariatric surgery experienced satisfactory weight loss. Data from a multinational bariatric surgery database has found that corrective procedures following primary bariatric surgery are relatively uncommon but generally safe and efficacious. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Adults with Type 2 Diabetes

For individuals who are diabetic and not morbidly obese who receive gastric bypass, SG, BPD, or LAGB, the evidence includes systematic reviews of RCTs and observational studies. Relevant outcomes are overall survival, 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 type 2 diabetes in obese patients, including those with a BMI between 30 and 34.9 kg/m^2. The greatest amount of evidence is on gastric bypass. Systematic reviews have found significantly greater remission rates of diabetes, decrease in hemoglobin A1c levels, and decrease in BMI with bariatric surgery than with nonsurgical treatment. The efficacy of surgery is balanced against the short-term risks of the surgical procedure. Most RCTs in this population have 1 to 3 years of follow-up; with a few having 5-year follow-up data. There are clinical concerns about durability and long-term outcomes at 5 to 10 years as well as potential variation in observed outcomes in community practice versus clinical trials. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Nondiabetic and Nonobese Adults

For individuals who are not diabetic and not morbidly obese who receive any bariatric surgery procedure, the evidence includes RCTs, nonrandomized comparative studies, and case series. Relevant outcomes are overall survival, change in disease status, functional outcomes, health

status measures, quality of life, and treatment-related mortality and morbidity. There is limited evidence for bariatric surgery in patients who are not diabetic or morbidly obese. 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 outcomes.

Adolescent Children with Morbid Obesity Gastric Bypass, Laparoscopic Adjustable Gastric Banding, or Sleeve Gastrectomy

For individuals who are adolescent children with morbid obesity who receive gastric bypass, or LAGB, or SG, the evidence includes RCTs, observational studies, and systematic reviews. Relevant outcomes are overall survival, 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.

Bariatric Surgery Other Than Gastric Bypass, Laparoscopic Adjustable Gastric Banding, or Sleeve Gastrectomy

For individuals who are adolescent children with morbid obesity who receive bariatric surgery other than gastric bypass, LAGB, or SG, the evidence includes systematic reviews and a cohort study. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Studies using bariatric surgery other than gastric bypass, LAGB, or SG, have small sample sizes. Results from a meta-analysis including patients using other procedures have shown significant improvements in BMI reduction, fasting blood insulin, and total cholesterol, although the estimates have wide confidence intervals, limiting interpretation. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome**.**

Preadolescent Children with Morbid Obesity

For individuals who are preadolescent children with morbid obesity who receive bariatric surgery, there are no studies focused on this population. Relevant outcomes are overall survival, 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, but findings were not reported separately for preadolescent children. Moreover, clinical practice guidelines have recommended

against bariatric surgery for preadolescent children. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome**.** However The American Academy of Pediatrics and the ASMBS recommend consideration of MBS in appropriately selected children and adolescents.

Hiatal Hernia Repair with Bariatric Surgery

For individuals with morbid 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 overall survival, 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 GERD remission, but not de novo GERD. 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.

V. DEFINITIONS

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N/A

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member’s health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits and which require preauthorization. There are different benefit plan designs in each product administered by Capital BlueCross. Members and providers should consult the member’s health benefit plan for information or contact Capital BlueCross for benefit information.

VII. DISCLAIMER

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Capital BlueCross’s medical policies are developed to assist in administering a member’s benefits, do not constitute medical advice, and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member’s benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member’s plan of benefits, please contact Capital BlueCross’ Provider Services or Member Services. Capital BlueCross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Investigational; therefore, not covered for bariatric surgery procedures listed as investigational above (Vertical-banded gastroplasty, Two stage gastric procedures, etc.):

Procedure Codes								
0813T	43842	43290	43291	C9784	C9785			

Covered when medically necessary:

Procedure Codes								
43289	43644	43645	43659	43770	43771	43772	43773	43774
43775	43843	43845	43846	43847	43848	43886	43887	43888
S2083								

ICD-10-CM Diagnosis Codes	Description
E66.01	Morbid (severe) obesity due to excess calories
K95.09	Other complications of gastric band procedure
K95.89	Other complications of other bariatric procedure
Z46.51	Encounter for fitting and adjustment of gastric lap band
Z68.30	Body mass index [BMI] 30.0-30.9, adult
Z68.31	Body mass index [BMI] 31.0-31.9, adult
Z68.32	Body mass index [BMI] 32.0-32.9, adult
Z68.33	Body mass index [BMI] 33.0-33.9, adult
Z68.34	Body mass index [BMI] 34.0-34.9, adult
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
Z68.52	Body mass index [BMI] pediatric, 5th percentile to less than 85th percentile for age

ICD-10-CM Diagnosis Codes	Description
Z68.53	Body mass index [BMI] pediatric, 85th percentile to less than 95th percentile for age
Z68.54	Body mass index [BMI] pediatric, greater than or equal to 95th percentile for age
Z98.84	Bariatric surgery status

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MP 1.015	**5/31/2019 Major review.** Criteria updated to further define conservative weight loss attempts and pre-operative program. Added smoking and age requirements. References updated. Effective 1/1/2020.
	3/18/2020 Minor review. Updated criteria to revised BMI requirements, defined requirements for conservative weight loss attempt, removed 6-month program requirement and added requirement for patient participation. References updated. Coding reviewed, no changes. Effective 7/1/2020.

	10/23/2020 Minor review. Single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S) was added to list of medically necessary bariatric surgeries per ASMBS recommendations. References updated.
	09/29/2021 Minor review. • Clarified tobacco use to include e-cigarettes or vaped tobacco, marijuana, or other substances. • Time frame for tobacco use changed from 6 months to 6 weeks. • For adults with BMI greater than or equal to thirty-five (35), added cardiovascular heart disease and hepatic steatosis criteria. • Pregnancy avoidance post op changed from 12 months to 12 to 18 months. • Removed timeframe from multi-disciplinary pre-op bariatric surgery program and added that the program should follow guidelines developed by the American Society of Metabolic and Bariatric Surgery. • Clarified mental health professional evaluation purpose • Removed "does not gain weight" from both adult and adolescent requirements during pre-op program. • For adolescents, removed additional criteria surrounding HTN as well as changed NASH to hepatic steatosis without active inflammation. Background and Rationale updated. References added. Updated FEP language added.
	12/1/2022 Admin Update: Added New Codes 43290 & 43291 Effective 1/1/23.
	12/20/2022 Minor Review. Title changed to "Metabolic and Bariatric Surgery". • Adult Criteria o Removed time frame of 2 years for sustainable weight loss o Removed criteria defining sustainable weight loss o BMI criteria for surgery categories changed to BMI > 35 without comorbidities or BMI ≥ 30 with comorbidities listed • Adolescent and Children criteria o Children now included in criteria indications o Removed criteria regarding Tanner Developmental Scale o BMI criteria for surgery categories changed to BMI >140% of the 95th percentile (class III obesity/BMI ≥ 40) or BMI > 120% of the 95th percentile (class II obesity/BMI ≥ 35) with obesity related comorbidities listed o Removed time frame for preoperative program o Added contraindications for surgery in adolescents and children • Revisions surgery o Added weight regain and GERD as examples of complications indicating need for revision • Policy Guidelines extensively revised to speak to conservative measure failure, specific guidance for the Asian population, high risk patients and BMI > 50 as well as abdominal wall hernia repair.

	• ICD 10 codes Z68.30 - Z68.45, Z68.52-Z68.54 added. Background, Rationale and References updated. Product variation and FEP language revised.
	6/13/2023 Admin Update: Added New Codes C9784 & C9785 Effective 7/1/23.
	12/12/2023 Admin Update: Added New Code 0813T. Effective 1/1/24.

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