Bariatric Surgery

DESCRIPTION

Obesity has a multifactorial cause that includes genetic, environmental, dietary as well as cultural and psychosocial aspects. When obesity reaches the level of 'morbid obesity', it is associated with adverse effects on almost all the organ systems and can dramatically decrease both life expectancy and quality of life. Therefore, consideration should also be given to the individual candidate requesting this elective procedure. The 2013 guidelines published by the by the American Association of Clinical Endocrinologists, the Obesity Society, and the American Society for Metabolic & Bariatric Surgery recommends all individuals considering bariatric surgery should undergo a pre-operative evaluation that includes: a comprehensive medical history, psychosocial history, physical exam, and appropriate testing to assess surgical risk.

Bariatric surgery is a treatment for extreme obesity in individuals who fail to lose weight with medical therapy and/or conservative measures. Weight loss surgery techniques fall into the following general categories:

- **Gastric restrictive surgical procedures** create a small gastric pouch, resulting in weight loss from early satiety and decreased dietary intake. The decreased capacity of the stomach reduces the volume of food an individual consumes before feeling full.

- **Malabsorptive surgical procedures** bypass a section of the small intestines. Weight loss results from intestinal malabsorption.

- **Combination surgical procedures** decrease the stomach capacity and bypassing part of the digestive tract, these techniques also result in metabolic changes due to gastrointestinal rearrangement.

Description of bariatric procedures:

**Biliopancreatic bypass procedure (BPB) (i.e., Scopinaro procedure):** Consist of subtotal gastrectomy using a long Roux-en-Y procedure to divert the biliopancreatic juices into the distal ileum. Because of the high incidence of cholelithiasis associated with the procedure, patients typically undergo an associated cholecystectomy.

**Biliopancreatic bypass with duodenal switch (BPB-DS):** It is essentially a variant of the biliopancreatic bypass. 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 biliopancreatic bypass, to create the alimentary limb.

**Long-Limb Gastric Bypass:** the stomach is 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.

**Gastric bypass using the Roux-en-Y anastomosis (RYGB):** Restricts the size of the stomach by stapling shut a large portion (up to 90%) of the lower stomach and performing a gastrojejunal anastomosis, thereby bypassing the duodenum. This can be done as a laparoscopic or open procedure.

**Gastric banding (LAGB):** Involves placing a gastric band around the outside of the stomach. The band is attached to a reservoir where saline can be injected to alter the diameter of the band thereby limiting the stoma in the stomach and systematically decreasing the capacity of the stomach. Complications include slippage of the external band or band erosion through the gastric wall.
Mini gastric bypass: Uses the laparoscopic approach, the stomach is segmented, similar to a traditional gastric bypass. Instead of creating a Roux-en-Y anastomosis, the jejunum is anastomosed incontinuity directly to the stomach, similar to a Billroth II procedure. The unique aspect of the procedure is not based on the laparoscopic approach, but rather the type of anastomosis used.

Minimally Invasive Procedures: (e.g., implantable sleeve and gastric plication procedures such as laparoscopic greater curvature plication or total vertical gastric plication) are addressed within a separate medical policy linked beneath the policy statements.

Sleeve gastrectomy (LSG): A form of unbanded gastroplasty; 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. Sleeve gastrectomy can be performed as an open or laparoscopic procedure. It can also be utilized as a first-stage bariatric procedure to reduce surgical risk in high-risk patients by induction of weight loss, and followed by subsequent surgical procedures to convert the sleeve gastrectomy to an intestinal bypass.

Single anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S): A small gastric sleeve is created, by sectioning the greater curvature of the stomach, such as in the Sleeve technique. A duodenum-intestinal anastomosis is performed, near ileocecal valve.

Vertical banded gastroplasty (VBG): Restricts the size of the stomach using a stapling technique. The stomach is segmented along its vertical axis. 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. There is no rearrangement of the intestinal anatomy.

While the majority of bariatric patients do achieve successful outcomes after their primary operation, individuals who present with insufficient weight loss, or weight regain after bariatric surgery represent a challenging population. Using the American Society for Metabolic and Bariatric Surgery (ASMBS) definitions a correction (revision) is a procedure that addresses complications of a previous bariatric operation. Complications include: gastric leaks, usually at the gastrojejunual junction; marginal ulcers; fistulas; bleeding; strictures; and obstructions. A conversion is a procedure that changes from the initial procedure to a different type of procedure. Conversion procedures are intended for individuals who experienced insufficient weight loss after the initial procedure (usually a LAGB) or experienced subsequent weight gain without a significant anatomic abnormality identified as a need for corrective surgery.

This policy does not address all minimally invasive techniques for weight loss surgery [e.g. implantable sleeve, Restorative Obesity Surgery Endoluminal (ROSE)]. Please see the BCBST policies specifically addressing these techniques (see hyperlinks below).

It is highly recommended that physicians utilize the Bariatric Surgery Precertification Request Form in order to simplify and speed up the pre-bariatric surgery review process.

Refer to the Bariatric Surgery Precertification Request Form

POLICY

The proposal is to add words in red text and to delete words or statements with a strikethrough:

- Bariatric surgery, using a laparoscopic or open procedure, for the treatment of obesity is considered medically necessary if the medical appropriateness criteria are met. (See Medical Appropriateness below.) (See also, brief description of various bariatric procedures above)

- Bariatric surgery for the treatment of obesity using the following techniques is considered investigational:

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Laparoscopic greater curve plication (LGCP) (i.e., total vertical gastric plication, gastric imbrication, gastric pleat)
Single anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S; or two stage bariatric procedures)

- Bariatric surgery for all other indications including but not limited to gastroesophageal reflux alone, glycemic control alone, lipid lowering alone or cardiovascular risk reduction alone independent of BMI criteria is considered investigational.

- Any device utilized for this procedure must have FDA approval specific to the indication, otherwise it will be considered investigational.

See Also:
- Minimally Invasive Procedures for Weight Loss
- Natural Orifice Transluminal Endoscopic Surgery
- Vagal Nerve Blocking Therapy for the Treatment of Obesity

MEDICAL APPROPRIATENESS

- Bariatric surgery is considered medically appropriate if ANY ONE of the following criteria are met:
  
  o An initial bariatric surgical procedure requested and ALL of the following:
    ▪ Individual is 18 years of age or older
    ▪ The Bariatric Surgery Precertification Request Form completed and submitted with the request for authorization
    ▪ Diagnosis of morbid obesity classified as ANY ONE of the following:
      ▪ Class 3 obesity with a BMI greater than or equal to 40 kg/m2
      ▪ Class 2 obesity with a BMI 35 to 39.9 kg/m2 with ANY ONE of the following obesity related comorbidities:
        o Coronary artery disease
        o Type 2 diabetes mellitus
        o Obstructive sleep apnea
        o Hypertension (BP greater than 140 mmHg systolic and/or 90 mmHg diastolic)
    ▪ Absence of ALL of the following excessive risk co-morbidities:
      ▪ Contraindications to general anesthesia
      ▪ Uncorrectable coagulopathy
      ▪ Irreversible cardiopulmonary disorders (e.g. right heart failure, severe pulmonary arterial hypertension, advanced cardiomyopathy)
      ▪ End-organ failure (e.g. end stage renal disease, candidate for transplant)
      ▪ Metastatic or inoperable malignancy
    ▪ Attending physician is someone other than the operating surgeon and his/her associates
    ▪ Attending physician documents adherence to a non-surgical weight loss program (e.g. dietary management, behavior modification, and/or exercise) with ALL of the following:
      ▪ Most recent attempt was within 2 years of request for surgery
      ▪ Participation was for a minimum of 6 months.
    ▪ Failure to achieve and/or maintain adequate weight loss (i.e. 10% or greater) by conservative means
    ▪ Comprehensive psychosocial - behavioral evaluation with ALL of the following:
Submitted by a Psychiatrist or Psychologist
Clinical interview completed no more than one (1) year prior to request for initial surgery
At least one psychological test and/or assessment tool administered and evaluated
(Possible choices: Minnesota Multiphasic Personality Inventory®, MMPI®, MMPI®-2-Restructured Form, or Millon® Behavioral Medicine Diagnostic with bariatric norms)
Absence of conclusion that individual is unable or unwilling to comply with requisite dietary and behavioral modifications.

- A correction (revision), conversion - alteration or reversal of a previous bariatric procedure with **ANY ONE** of the following:
  - Physician documented medical complication
  - Physician documented surgical complication related to the original surgery (e.g., fistula, obstruction, erosion, disruption/leakage of a suture/staple line, band herniation, or pouch enlargement not due to overeating)
  - Inadequate weight loss or weight regained when **ALL** of the following are met:
    - The requested procedure is not an investigational procedure
    - Individual meets all of the criteria for an initial bariatric procedure (Note: documentation submitted for the initial bariatric surgery does not count toward meeting the criteria for the conversion procedure.)
    - Request is two (2) years or more since the initial surgery
    - Weight loss is less than 50% of initial procedure pre-operative excess body weight
    - Weight remains at least 30% over **ideal body weight** (i.e. BMI not over 24.9)

**IMPORTANT REMINDERS**

- Any specific products referenced in this policy are just examples and are intended for illustrative purposes only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available. These examples are contained in the parenthetical e.g. statement.

- We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits, or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the Medical Policy and a health plan, the express terms of the health plan will govern.

*This medical policy does not apply to the State of TN Member Contract.*

*This medical policy does not apply to CoverTN, or CoverKids.*

**ADDITIONAL INFORMATION**

**The cost of bariatric surgery for the treatment of morbid obesity may or may not be covered by insurance.**

In 2016 the Center for Disease Control (CD) classified adult body mass index (BMI) for obesity as:

- **Class 1** obesity is BMI 30 to 34.9
- **Class 2** obesity is BMI 35 to 39.9
- **Class 3** obesity is BMI greater than or equal to 40

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Well-designed clinical trials, addressing other procedures (e.g., cholecystectomy, liver biopsy) performed at the same time as bariatric surgery, are not available. Well-designed prospective studies are emerging to better define the place for adolescent bariatric surgery. As always, each separate procedure must independently be determined to be clinically appropriate to be considered medically necessary.

**SOURCES**


Agency for Healthcare Research and Quality, Department of Health & Human Services. (2013, June) *Bariatric surgery and nonsurgical therapy in adults with metabolic conditions and a body mass index of 30.0 to 34.9 kg/m2* Comparative Effectiveness Review Number 82. Received October 21, 2015 from: [wwwahrq.gov](http://wwwahrq.gov).


Medical Policy Manual

Draft: Revised Policy Do Not Implement


Technology Evaluation Center. (2012, October). *Bariatric surgery in patients with diabetes and BMI less than 35 kg/m2 with weight.* (Vol. 27, No. 2). Chicago: BlueCross BlueShield Association. (33 articles and/or guidelines reviewed)

Technology Evaluation Center. (2012, October). *Laparoscopic adjustable gastric banding in patients with BMI less than 35 kg/m2 with weight related comorbidity.* (Vol. 27, No. 5). Chicago: BlueCross BlueShield Association. (19 articles and/or guidelines reviewed)


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EFFECTIVE DATE

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