Bariatric Surgery

LOB(s):	State(s):
☒ *Commercial* ☒ *Medicare*	☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon*

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Bariatric surgery is intended to provide sufficient weight loss to reduce morbidity and mortality risk and improve medical conditions when less invasive methods of weight loss, such as physician supervised weight loss programs or obesity disease management programs, have not been successful.

According to the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC), obesity is having a higher weight than what is considered healthy for a given height. Overweight and obesity are also defined as abnormal or excessive fat accumulation that presents a risk to health. Body Mass Index (BMI) is a screening tool used to determine obesity. The WHO states that body mass index (BMI) over 25 is considered overweight, and over 30 is obese. BMI is calculated by dividing member's weight (kilograms) by height (meters squared). (BMI = weight (kg) / height $(m)^2$).

The National Institute of Health has a BMI calculator that can be found at:
https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm

Criteria

Commercial

Bariatric surgery, including revisions, are subject to specific member plan benefits. Bariatric surgery is not covered in plans without a benefit. All health plans with a bariatric surgery benefit **do not require prior authorization**; except for Billings Clinic Employee Health Plan (BCEHP) and Legacy Employee Health Plan (LEHP).

Medicaid

PacificSource Community Solutions follows Guideline Note 8 of the Health Evidence Review Commission (HERC) Prioritized List of Health Services and the general coverage requirements, limitations, and exclusions outlined in OARs 410-141-3820 and 410-141-3825 to determine coverage of bariatric surgery, including repeat surgeries, reversals, repairs, and single anastomosis duodenal-ileal bypass with sleeve (SADI-S) coded CPT 43999.

PacificSource Community Solutions follows Excluded Services Guideline E2of the Health Evidence Review Commission (HERC) Prioritized List of Health Services for the following procedures which have been determined to have insufficient or no evidence of effectiveness:

- Intragastric bariatric balloon esophagogastroduodenoscopy (43290)
- Transoral outlet reduction endoscopy (C9785)
- Gastric restrictive procedures (43770)

PacificSource Community Solutions (PCS) follows EPSDT coverage requirements in OAR 410-151-0002 for EPSDT beneficiaries. Coverage of bariatric surgery is determined through case-by-case reviews for EPSDT Medical Necessity and EPSDT Medical Appropriateness defined in OAR 410-151-0001. The coverage guidance for bariatric surgery in Guideline Notes 8 and Excluded Services Guideline E2 of the Prioritized List may be used to assist in informing a determination of medical necessity and medical appropriateness during the individual case review.

PacificSource Community Solutions (PCS) follows the internal policy Unlisted and Unspecified Procedure Codes for Reimbursement Purposes for all requests containing Unlisted Procedure codes.

PacificSource Community Solutions (PCS) follows OAR 410-130-0160(2)(c) for coverage of CPT 0813T. PCS does not consider this a treatment a covered service.

Medicare

PacificSource Medicare follows National Coverage Determination (NCD) 100.1 for coverage of bariatric surgery.

Experimental/Investigational/Unproven

PacificSource considers bariatric surgery to be experimental, investigational, or unproven when performed as primary treatment for any other indication than obesity (e.g., gastroparesis, intractable nausea, gallstones, urinary stress incontinence, gynecological abnormalities, osteoarthritis, idiopathic intracranial hypertension).

PacificSource considers the following procedures for treating obesity as experimental, investigational, or unproven:

- Implantable gastric electrical stimulation (GES) or gastric pacing

- Intragastric balloon procedures (e.g., Obalon Balloon System, Orbera, ReShape Integrated Dual Balloon System)
- Laparoscopic mini-gastric bypass (LMGBP)/mini-gastric bypass (MGB)
- Silastic ring vertical gastric bypass (Fobi Pouch)*
- Laparoscopic gastric plication (also known as laparoscopic greater curvature plication [LGCP]), with or without gastric banding
- Transoral endoscopic surgery (includes TransPyloric Shuttle® (TPS® Device)
- Transoral gastroplasty (TOGA) (vertical sutured gastroplasty; endoluminal vertical gastroplasty; endoscopic sleeve gastroplasty)
- Gastrointestinal liners (endoscopic duodenal-jejunal bypass, endoscopic gastrointestinal bypass devices; (e.g., EndoBarrier and the ValenTx Endo Bypass System)
- Endoscopic sleeve gastroplasty (e.g., Apollo ESG)
- Endoscopic transoral outlet reduction (transoral outlet reduction (TORe)
- Vagus/vagal nerve blocking (e.g., the VBLOC device, also known as the Maestro Implant or the Maestro Rechargeable System)*

Note: * indicates the item remains E/I/U but will not be reviewed annually by the NTOC Committee, unless requested.

Note: PacificSource Community Solutions (PCS) and PacificSource Medicare require items listed on this policy's E/I/U list, to be reviewed by medical necessity review guidelines. Please see related policy, "Clinical Criteria Used in UM Decisions" to review criteria hierarchy and "Medical Necessity Reviews" for determination of coverage and medical necessity guidelines.

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

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)
43499	Unlisted procedure, esophagus
43621	Gastrectomy, total; with Roux-en-Y reconstruction
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction
43644	Laparoscopy, Surg, Gastric Restrictive Procedure; W Gastric Bypass And Roux-En-Y Gastroenterostomy (Roux Limb < 150 cm)

43645 Laparoscopy, Surgical, Gastric Restrictive Procedure; With Gastric Bypass And Small Intestine Reconstruction (Roux Limb >/= 150 cm)

43647 Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum

43648 Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum

43659 Unlisted Proc, Laparoscopy, Stomach

43770 Laparoscopy, surg, gastric restrictive procedure; placement of adjustable gastric band

43771 Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric band component only

43772 Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band component only

43773 Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric band component only

43774 Laparoscopy, surg, gastric restrictive procedure; removal of adjustable gastric band and subcutaneous port components

43775 Laparoscopy, Surgical, Gastric Restrictive Procedure; Longitudinal Gastrectomy (i.e., Sleeve Gastrectomy

43842 Gastric Restrictive Proc, W/O Gastric Bypass, Morbid Obesity; Vertical-Banded Gastroplasty

43843 Gastric Restrictive Proc, W/O Gastric Bypass, Morbid Obesity; Non-Vertical-Banded Gastroplasty

43845 Gastric Stapling Morbid Obesity

43846 Gastric Restrictive Procedure, W/Gastric Bypass, Morbid Obesity; W/Short Limb Roux-En-Y Gastroenterostomy

43847 Gastric Restrictive Proc, W/Gastric Bypass, Morbid Obesity; W/Small Bowel Reconstruction

43848 Revision, Gastric Restrictive Proc, Morbid Obesity (Sep Proc)

43881 Implantation or replacement of gastric neurostimulator electrodes, antrum, open

43882 Revision or removal of gastric neurostimulator electrodes, antrum, open

43886 Gastric restrictive procedure, open; revision of subcutaneous port component only

43887 Gastric restrictive procedure, open; removal of subcutaneous port component only

43888 Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only

43889 Gastric restrictive procedure, transoral, endoscopic sleeve gastroplasty (ESG), including argon plasma coagulation, when performed

43999 Unlisted procedure, stomach

49999 Unlisted procedure, abdomen, peritoneum, and omentum

64590 Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling

64595 Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver

64999 Unlisted procedure, nervous system

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

S2083 Adjustment gastric band

CPT® codes, descriptions and materials are copyrighted by the American Medical Association (AMA).

HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

Related Policies

Category III Current Procedural Terminology (CPT) Codes

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Gastric Pacing and Gastric Electrical Stimulation (GES) for Gastroparesis

New and Emerging Technologies - Coverage Status

Unlisted and Unspecified Procedure Codes

Utilization Management Clinician Determinations of Non-Coverage

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Oregon Health Authority. The Health Evidence Review Commission (HERC) Prioritized List of Health Services https://www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx

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Appendix

Policy Number:

Effective: 7/1/2020 **Next review:** 10/1/2026

Policy type: Enterprise

Author (s):

Depts: Health Services

Applicable regulation(s): OARs 410-130-0160(2)(c), 410-141-3820, 410-141-3825, 410-151-0001, 410-151-0002; NCD 100.1

OPs Approval: 7/2026