



Medica Central Utilization Management Policy

Title: BARIATRIC SURGERY MP9319

Effective Date: January 01, 2025

This policy was developed with input from specialists in general and bariatric surgery and endorsed by the Medical Policy Committee.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica Central plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions may call the Provider Service Center. Please use the Quick Reference Guide on the Provider Communications page for the appropriate phone number. <https://mo-central.medica.com/Providers/SSM-employee-health-plan-for-IL-MO-OK-providers>

Medica Central coverage policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment.

PURPOSE

To promote consistency between utilization management reviewers by providing the criteria that determines the medical necessity.

BACKGROUND

I. Definitions

- A. **Bariatric surgical preparatory program** is a multi-disciplinary approach to preoperative care of the bariatric patient. It encompasses bariatric surgical procedure education; dietary, nutrition, and exercise counseling; management of comorbidities; nursing care; and psychological evaluation and counseling, as warranted.
- B. **Body Mass Index (BMI)** is a formula that uses a person's body mass (height and weight) to estimate that person's risk for morbidity and premature mortality. (See *Appendix 1 – Body Mass Index [BMI] Conversion Table*.) A BMI between 35 and 39 is viewed as a very high health risk, while a BMI of 40 or more is viewed as an extremely high health risk. The BMI associated with the lowest mortality is between 20 and 25. **Note:** BMI is not to be used with certain groups of people (i.e., athletes, body builders, or pregnant women) who have high BMIs due to muscle mass, fetal tissue, etc.
- C. **Combined restrictive and malabsorptive surgical procedures** restrict meal size and may alter the digestion process, thus causing food to be incompletely absorbed. Examples of combined restrictive and malabsorptive procedures include Roux-en-Y gastric bypass and biliopancreatic diversion with duodenal switch.
- D. **Estimates of adult height** are qualitative indices that assist a caregiver in determining whether a child is growing as expected. One commonly used tool is a growth chart, which

Medica Central Utilization Management Policy

records a child's height, weight, and head size over time. Other methods are the 'two years times two' method (i.e., doubling a boy's height at age two; doubling a girl's height at 18 months) or a mid-parental height adjustment measurement.

- E. **Obesity** is a condition in which excessive body fat compromises organ systems, psychosocial well-being, and overall quality of life. The Centers for Disease Control and Prevention (CDC) defines weight higher than what is considered healthy for a given height as being overweight or obese. Body Mass Index (BMI) is a screening tool for overweight and obesity. Overweight is defined as a body mass index (BMI) of 25 to less than 30. The CDC ranks obesity into the following classes:
 - 1. Class 1: BMI of 30 to less than 35
 - 2. Class 2: BMI of 35 to less than 40
 - 3. Class 3: BMI of 40 or higher. Class 3 obesity is sometimes referred to as severe obesity.
- F. **Restrictive surgical procedures** reduce the size of the stomach and limit the amount of food that can be ingested at one time. Surgical incision and resection of the intestine is not involved. Examples of purely restrictive operations for obesity include adjustable silicone gastric banding (LapBand), sleeve gastrectomy, and vertical banded gastroplasty.
- G. **Skeletal (bone) maturity** occurs when bone growth ceases after puberty and refers to demonstration of fusion of skeletal bones. Females reach skeletal maturity at approximately 16 years of age, while males reach skeletal maturity around 18 years of age. Radiographs of either the knee or of the hand and wrist with subsequent mathematical calculations are often used when exact measurement of skeletal maturity is warranted.
- H. **Substance use disorder**, as defined by the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is a problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress. The symptoms associated with a substance use disorder fall into four major groupings: impaired control, social impairment, risky use, and pharmacological criteria (i.e., tolerance and withdrawal).
- I. **Super-obesity** refers to overweight individuals with a BMI of 50-60. Patients with BMI >60 are classified as **super-super obese**.
- J. **Sexual Maturity Rating** (aka, Tanner stage/Tanner scale) is a measure of physical development in children, adolescents, and adults. The scale is named after its originator, James Tanner, a British pediatrician. The scale defines physical measurement of maturity based on external primary and secondary sex characteristics, such as breast or genital size, testicular volume, and development of pubic hair. (*See Appendix 2 – Tanner Stages*).
- K. **Weight loss surgery** encompasses major operations with significant risks of complications. The risks are reduced if the operation and follow-up care are performed by a specialist in bariatric surgery.

II. Common surgical interventions

A. Purely Restrictive procedures:

- 1. **Vertical banded gastroplasty** consists of constructing a small pouch by placing a vertical staple line along the lesser curvature of the stomach. An opening (or stoma) is created at the distal end of the pouch to allow food to pass normally, but more slowly, from the pouch to the stomach and then to the small intestines. The pouch generally holds about one ounce of food. The person feels full quickly and experiences pain, nausea and/or vomiting when overeating. Both open and laparoscopic techniques are performed for this procedure.
- 2. **Adjustable silicone gastric banding** is similar in intent to the vertical banded gastroplasty except that an inflatable, adjustable silicone band is laparoscopically inserted around the upper stomach to create a small stomach pouch. An injection reservoir is enclosed under the skin's surface. The inflatable inner surface of the band is then injected with saline to a level suitable for food restriction and subsequent weight

Medica Central Utilization Management Policy

loss, as well as patient comfort. The degree of inflation can be adjusted by a clinician as needed. By removing the silicone band, the procedure can be reversed with minimal need for stomach reconstruction. Although most commonly inserted laparoscopically, this procedure can also be done using an open incision.

3. **Sleeve gastrectomy** is a restrictive procedure that is accomplished by removing the outer portion (upper curvature) of the stomach. This leaves a small sleeve of stomach, reducing stomach volume as much as 80 percent. The procedure was originally designed as the first step of a restrictive/malabsorption staged procedure but is recently being suggested as a primary (one stage) procedure.
- B. Combined Restrictive and Malabsorptive procedures:
 1. **Roux-en-Y gastric bypass** and its variants consist of two basic steps: creating a small stomach pouch and re-routing the intestines to connect to the pouch. First, a small gastric pouch is constructed, thereby partitioning the pouch from the remaining stomach. The intestine is cut, and the distal end of the bowel is attached to the pouch where the stoma is created. The remaining intestinal limb is reattached farther down the intestinal tract, thereby creating a Y-shaped limb of varying lengths. Gastric bypass procedures work by restricting food intake and by limiting the absorption of calories and nutrients. A gastric bypass is both a gastric restrictive and a malabsorptive procedure. Both open and laparoscopic techniques are performed for this procedure.
 2. **Biliopancreatic diversion with duodenal switch** combines biliopancreatic/intestinal bypass and stomach size reduction. First, a sleeve gastrectomy is done, creating a smaller stomach with both the esophageal connection and the pylorus valve remaining intact. Next, a shorter alimentary limb that carries food is created by connecting the ileum to just beyond the pylorus. A longer biliary limb runs from the duodenum and carries bile and pancreatic secretions. The biliary limb is then connected to the alimentary limb, creating a short common channel where limited fat absorption can occur prior to content entry into the colon. This procedure is primarily malabsorptive, with less restriction than that in the Roux-en-Y gastric bypass. Both open and two-stage laparoscopic techniques are performed for this procedure.

BENEFIT CONSIDERATIONS

1. Prior authorization **is required** for gastrointestinal surgery for obesity for the initial surgical procedure, for a surgical revision, and for a second procedure. Please see the prior authorization list for product specific prior authorization requirements.
2. Coverage may vary according to the terms of the member's plan document.
3. Gastrointestinal surgical procedures for obesity or surgery for weight loss not specifically mentioned in the Medical Necessity Criteria section *are investigative and therefore not covered*. These include, but are not limited to:
 - a. Open loop gastric bypass ("mini" gastric bypass; omega loop gastric bypass; single-anastomosis gastric bypass)
 - b. Unmodified biliopancreatic diversion
 - c. Combined vertical banded gastroplasty-gastric bypass
 - d. Magenstrasse and Mill Procedure (laparoscopic non banded vertical gastroplasty)
 - e. Single-Anastomosis Duodenal Switch, stand-alone procedure (aka, stomach intestinal pylorus-sparing surgery; SIPS)
 - f. Transected silastic ring vertical gastric bypass (Fobi pouch)
 - g. Transoral endoscopic procedures for obesity including, but not limited to, natural orifice transluminal endoscopic surgery and endoscopic revision following bariatric surgery (all methods including, but not limited to, endoluminal suturing and/or stapling, prosthetic insertion [e.g., intragastric balloon; endoluminal sleeve], or endoscopic sclerosant injection).



Medica Central Utilization Management Policy

4. A second procedure for gastrointestinal surgery for obesity in the absence of complications *is not covered*.
5. A reversal (takedown) of gastrointestinal surgery for obesity in the absence of complications *is not covered*.
6. The following services *are NOT covered*:
 - a. Education classes
 - b. Liquid protein diet replacements/supplements
 - c. Over the counter appetite suppressants/weight loss medications
 - d. Over-the-counter vitamin and/or mineral supplements
 - e. Weight loss program fees.
7. If the Medical Necessity Criteria and Benefit Considerations are met, Medica will authorize benefits within the limits in the member's plan document.
8. If it appears that the Medical Necessity Criteria and Benefit Considerations are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeal process in their Medica administrative handbook.

MEDICAL NECESSITY CRITERIA

- I. Indications for initial procedure in individuals over 18 years of age
Gastrointestinal surgery for obesity is considered medically necessary when documentation in the medical record indicates that **all of the following** criteria are met:
 - A. **One of the following** procedures is being requested:
 1. Open or laparoscopic Roux-en-Y (RNY) gastric bypass
 2. Laparoscopic adjustable silicone gastric banding
 3. Open or laparoscopic sleeve gastrectomy
 4. Open or laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS)
 5. Single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S).
 - B. Psychiatric/psychological evaluation has been conducted by a *licensed* mental health professional, and **all of the following** are documented:
 1. Evaluation has been completed within the past 12 months.
 2. Confirmation of the individual's understanding of the full impact of surgery, including the risks and goals of the surgical procedure.
 3. Documentation of relevant behavioral health issues to be addressed as they pertain to post-surgical recovery and weight loss.
 4. Confirmation of individual's understanding of the importance of the after-care plan.
 - C. The initial pre-surgical consultation with the bariatric surgical preparatory team has occurred at least one month prior to the date of surgery.
 - D. **One of the following** is documented:
 1. A BMI **equal to or greater than 40**, and **all of the following** are documented:
 - a. BMI recorded at least one-month preceding surgery.
 - b. Participation in a diet, nutrition, and exercise counseling regimen as recommended and documented by the bariatric surgical preparatory team. -
 2. A BMI **between 35 and 39.9**, and **all of the following** are documented:
 - a. BMI recorded at least one-month preceding surgery.
 - b. **One of the following** comorbidities documented in the medical record:
 - i. Diabetes mellitus requiring prescription medication or a documented glycosylated hemoglobin (HgbA1c) level at or above 8 documented within the 12 months prior to surgical intervention.
 - ii. Clinically significant hyperlipemia or dyslipidemia requiring medical management or a documented LDL level greater than 130 milligrams per deciliter.

Medica Central Utilization Management Policy

- iii. Hypertension requiring medical management or blood pressure equal to or greater than 140 mmHg systolic and/or 90 mmHg diastolic documented on more than one occasion.
 - iv. Obstructive sleep apnea requiring CPAP or other related sleep apnea treatment.
 - v. Significant gastroesophageal reflux disease (GERD) (e.g., esophagitis with open reflux/transient lower esophageal sphincter relaxation when Nissen fundoplication has been previously determined not appropriate.)
 - vi. Non-alcoholic steatohepatitis (NASH)
 - vii. Metabolic associated fatty liver disease
 - c. Participation in a diet, nutrition, and exercise counseling regimen as recommended and documented by the bariatric surgical preparatory team.
- 3. A BMI of 30 to 34.9 (27.5 in Asian patients) with type 2 diabetes mellitus and inadequately controlled hyperglycemia despite optimal medical treatment (eg, oral medication, insulin).
- II. Indications for initial procedure in individuals less than or equal to 18 years of age
Gastrointestinal surgery for obesity is considered medically necessary when documentation in the medical record indicates **all of the following** criteria are met:
 - A. The individual meets criteria I.A.-D2. c., above,
 - B. Greater than 95% of estimated adult height has been achieved based on previously documented individual growth pattern (e.g., two years times two measurement, mid-parental measurement, growth chart tracking)
 - C. A minimum Tanner stage of IV. (See Appendix 2.)
- III. Indications for surgical revisions
Surgical revision following previous gastrointestinal surgery for obesity is considered medically necessary when documentation in the medical record indicates that **all of the following** criteria are met:
 - A. **One of the following** procedures is being requested:
 - 1. Open or laparoscopic Roux-en-Y (RNY) gastric bypass
 - 2. Open or laparoscopic sleeve gastrectomy
 - 3. Open or laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS)
 - 4. Removal of adjustable gastric band and/or port
 - 5. Vertical banded gastroplasty (VBG).
 - B. Documentation in the medical record that the BMI prior to the initial procedure was equal to or greater than 35.
 - C. Documentation in medical record of a surgical complication following the primary procedure and related medical confirmation (e.g., imaging results, endoscopic reports).
NOTE: Examples of complications include, but are not limited to:
 - 1. Stoma ulcer or dilation
 - 2. Mechanical obstruction
 - 3. Significant malnutrition
 - 4. Stenosis
 - 5. Leakage (e.g., from staple line breakdown, distal stricture, band, port, tubing)
 - 6. Esophageal or pouch dilation
 - 7. Uncontrollable gastroesophageal reflux (with or without hiatal hernia), esophagitis, and/or vomiting
 - 8. Gastric band erosion or slippage of gastric band or port
 - 9. Infection around hardware (e.g., port used for band adjustments, staple line)
 - 10. New or recurrent hiatal hernia
 - 11. Gastric hemorrhage
 - 12. Hardware failure/malfunction of a mechanical device
 - ~~13. Gastrogastric fistula.~~



Medica Central Utilization Management Policy

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

- For Medicare members, refer to the following, as applicable at:
<https://www.cms.gov/medicare-coverage-database/new-search/search.aspx>

WISCONSIN BADGERCARE PLUS

- For members with State of Wisconsin BadgerCare Plus review Forward Health website for coverage and prior authorization requirements. ([Forward Health WI Portal](#))

DOCUMENT HISTORY

Original Effective Date	Created 05/12/2004
MPC Endorsement Date(s)	10/13/2004, 03/09/2005, 03/06/2005, 03/14/2007, 07/12/2006, 06/13/2007, 01/16/2008, 03/12/2008, 08/10/2008, 04/08/2009, 11/11/2009, 09/22/2010, 09/28/2011, 01/18/2012, 09/19/2012, 07/17/2013, 07/16/2014, 07/15/ 2015, 12/19/2015, 07/20/2016, 05/17/2017, 07/19/2017 02/21/2018, 04/18/2018, 08/15/2018, 11/21/2018, 05/15/2019, 10/16/2019, 08/19/2020, 01/20/2021, 05/19/2021, 04/20/2022, 06/15/2022, 08/16/2023, 04/17/2024
Administrative Updates	03/2006, 04/17/2024, 09/24/2024

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Medica Central Utilization Management Policy

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Medica Central Utilization Management Policy

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Medica Central Utilization Management Policy

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Medica Central Utilization Management Policy

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04/2024 MPC:

No new references

Medica Central Utilization Management Policy

APPENDIX 1 – Body Mass Index (BMI) Conversion Table

Body Mass Index Table																																							
Normal										Overweight										Obese										Extreme Obesity									
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54			
Height (Inches)	Body Weight (pounds)																																						
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258			
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267			
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276			
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285			
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295			
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304			
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314			
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324			
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334			
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344			
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354			
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365			
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376			
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386			
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397			
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408			
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420			
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431			
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443			

The BMI describes relative weight for height. It is calculated as weight (in kilograms) / height (in meters) squared. The National Heart, Lung, and Blood Institute (NHLBI) guidelines classify overweight as a BMI of 25 through 29.9 kg/meter squared, obesity as a BMI equal to or greater than 30 kg/meter squared, and extreme obesity as a BMI equal to or greater than 40 kg/meter squared.

Adapted from: National Heart Lung and Blood Institute. Clinical Guidelines on the Identification, Evaluation and

Medica Central Utilization Management Policy

APPENDIX 2 – Tanner Stages

Because the onset and progression of puberty are so variable, Tanner has proposed a scale, now uniformly accepted, to describe the onset and progression of pubertal changes. Boys and girls are rated on a 5 point scale. Boys are rated for genital development and pubic hair growth, and girls are rated for breast development and pubic hair growth.

Pubic hair growth in females is staged as follows:

- Stage I (Preadolescent) - Vellos hair develops over the pubes in a manner not greater than that over the anterior wall. There is no sexual hair.
- Stage II - Sparse, long, pigmented, downy hair, which is straight or only slightly curled, appears. These hairs are seen mainly along the labia. This stage is difficult to quantitate on black and white photographs, particularly when pictures are of fair-haired subjects.
- Stage III - Considerably darker, coarser, and curlier sexual hair appears. The hair has now spread sparsely over the junction of the pubes.
- Stage IV - The hair distribution is adult in type but decreased in total quantity. There is no spread to the medial surface of the thighs.
- Stage V - Hair is adult in quantity and type and appears to have an inverse triangle of the classically feminine type. There is spread to the medial surface of the thighs but not above the base of the inverse triangle.

The stages in male pubic hair development are as follows:

- Stage I (Preadolescent) - Vellos hair appears over the pubes with a degree of development similar to that over the abdominal wall. There is no androgen-sensitive pubic hair.
- Stage II - There is sparse development of long pigmented downy hair, which is only slightly curled or straight. The hair is seen chiefly at the base of penis. This stage may be difficult to evaluate on a photograph, especially if the subject has fair hair.
- Stage III - The pubic hair is considerably darker, coarser, and curlier. The distribution is now spread over the junction of the pubes, and at this point that hair may be recognized easily on black and white photographs.
- Stage IV - The hair distribution is now adult in type but still is considerably less than seen in adults. There is no spread to the medial surface of the thighs.
- Stage V - Hair distribution is adult in quantity and type and is described in the inverse triangle. There can be spread to the medial surface of the thighs.

In young women, the Tanner stages for breast development are as follows:

- Stage I (Preadolescent) - Only the papilla is elevated above the level of the chest wall.
- Stage II - (Breast Budding) - Elevation of the breasts and papillae may occur as small mounds along with some increased diameter of the areolae.
- Stage III - The breasts and areolae continue to enlarge, although they show no separation of contour.
- Stage IV - The areolae and papillae elevate above the level of the breasts and form secondary mounds with further development of the overall breast tissue.
- Stage V - Mature female breasts have developed. The papillae may extend slightly above the contour of the breasts as the result of the recession of the areolae.

The stages for male genitalia development are as follows:

- Stage I (Preadolescent)- The testes, scrotal sac, and penis have a size and proportion similar to those seen in early childhood.
- Stage II - There is enlargement of the scrotum and testes and a change in the texture of the scrotal skin. The scrotal skin may also be reddened, a finding not obvious when viewed on a black and white photograph.
- Stage III - Further growth of the penis has occurred, initially in length, although with some increase in circumference. There also is increased growth of the testes and scrotum.
- Stage IV - The penis is significantly enlarged in length and circumference, with further development of the glans penis. The testes and scrotum continue to enlarge, and there is distinct darkening of the scrotal skin. This is difficult to evaluate on a black-and-white photograph.
- Stage V - The genitalia are adult with regard to size and shape.

Source: Reprinted with permission from Feingold, David. "Pediatric Endocrinology" in *Atlas of Pediatric Physical Diagnosis, Second Edition*, Philadelphia W.B. Saunders, 1992, 9.16-19.