Clinical Policy: Bariatric Surgery - FEHB

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Public Statement

Effective Date:

1. This policy will apply to all services performed on or after the above revision date which will become the new effective date.

2. For all services referred to in this policy that were performed before the revision date, contact customer service for the rules that would apply.
   1) This policy is specific to the Federal Employees Health Benefits.
   2) Consult your FEHBP plan for more details.
   3) Obesity surgery also known as bariatric surgery requires pre-authorization for this group.

Medical Statement

1) **This policy applies only to members covered by the Federal Employees Health Benefits Program medical plan**. For members of all other groups, please see the appropriate Medical Policy.

2) Under the Federal Employees Health Benefits Program, Obesity (Bariatric) surgery requires preauthorization.

3) General Selection criteria: Must meet all criteria 1 through 5
   a) Presence of severe obesity that has persisted for at least 3 years, defined as **any of the following:**
      i) Body mass index (BMI) (see notes) exceeding 40 (Z68.41-Z68.45); **or**
      ii) BMI greater than 35 (Z68.35-Z68.39) in conjunction with **any** of the following severe co-morbidities:
         (1) Coronary heart disease (I20.8-I25.9); **or**
         (2) Diabetes mellitus (E11.0-E11.9); **or**
         (3) Clinically significant obstructive sleep apnea (G47.33); **or**
         (4) Medically refractory hypertension (I10-I15.9) (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management) **and**;
   b) Member must be between the ages of 18-64; **and,**
   c) Have a documented length of condition of at least 3 years; **and**,

d) The member has had a psychological evaluation by a qualified mental health clinician, which may include but is not limited to a psychiatrist or psychologist; **and**
e) Member must meet one of following:
   i) Member has participated in clinically supervised nutrition and exercise program (including dietician consultation, low calorie diet, exercise counseling, and behavioral modification, and pharmacologic therapy, if appropriate), documented in the medical record. This clinically-supervised nutrition and exercise program must meet *all* of the following criteria:
      (1) Nutrition and exercise program must be supervised and monitored in a clinical setting and working in cooperation with dieticians and/or nutritionists; **and**
      (2) Nutrition and exercise program(s) must be for a cumulative total of 12 months or longer in duration and occur within 2 years prior to surgery. **and**
   ii) Proximate to the time of surgery, member must participate in organized multidisciplinary surgical preparatory regimen of at least three months duration in order to improve surgical outcomes, reduce the potential for surgical complications, and establish the member`s ability to comply with post-operative medical care and dietary restrictions.
      (1) Examples of multidisciplinary Regimen.
         (a) Consultation with a dietician or nutritionist;
         (b) Reduced-calorie diet program supervised by dietician or nutritionist;
         (c) Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by exercise therapist or other qualified professional;
         (d) Behavior modification program supervised by qualified professional;
         (e) Documentation in the medical record of the member`s participation in the multidisciplinary surgical preparatory regimen.

4) <u>Roux-en-Y Gastric Bypass (RYGB) and Laparoscopic Adjustable Silicone Gastric Banding (LASGB)</u>:
   i) Open or laparoscopic Roux-en-Y gastric bypass (RYGB) or laparoscopic adjustable silicone gastric banding (LASGB or Lap-Band) is considered medically necessary when the selection criteria above are met.

5) <u>Vertical Banded Gastroplasty (VBG)</u>:
   i) Open or laparoscopic vertical banded gastroplasty (VBG) is considered medically necessary for members who meet the selection criteria for obesity surgery **and** who are at increased risk of adverse consequences of a RYGB due to the presence of **any** of the following comorbid medical conditions:
   b) Hepatic cirrhosis with elevated liver function tests (K74.0, K74.60 - K74.69, R94.5); ***or***
   c) Inflammatory bowel disease (Crohn`s disease or ulcerative colitis) (K50.00 - K51.919); ***or***
   d) Radiation enteritis (K52.0); ***or***
   e) Demonstrated complications from extensive adhesions involving the intestines from prior major abdominal surgery, multiple minor surgeries, *or* major trauma; **or**
   f) Poorly controlled systemic disease (American Society of Anesthesiology (ASA) Class IV).

6) Repeat Bariatric Surgery:
Repeat bariatric surgery is considered medically necessary when the initial bariatric surgery was medically necessary (i.e., who met medical necessity criteria), and when either of the following medical necessity criteria is met:
   a) Conversion to a RYGB may be considered medically necessary for members who have not had adequate success (defined as loss of more than 50 percent of excess body weight) two years following the primary bariatric surgery procedure and the member has been compliant with a prescribed nutrition and exercise program following the procedure; **or**
   b) Revision of a primary bariatric surgery procedure that has failed due to dilation of the gastric pouch is considered medically necessary if the primary procedure was successful in inducing weight loss prior to the pouch dilation, and the member has been compliant with a prescribed nutrition and exercise program following the procedure

7) Elective cholecystectomy at the time of the covered obesity surgery will be covered.

Notes:
Calculation of BMI:
BMI is calculated by dividing the patient`s weight (in kilograms) by height (in meters) squared:
BMI = weight (kg) * [height (m)] 2
to convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254.
A BMI calculation module can be found here:
https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm

Codes Used In This BI:

00797	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity
43644	Lap gastric bypass/roux-en-y
43645	Lap gastr bypass incl smll i
43770	Lap place gastr adj device
43771	Lap revise gastr adj device
43772	Lap rmvl gastr adj device
43773	Lap replace gastr adj device
43774	Lap rmvl gastr adj all parts

43842	V-band gastroplasty
43843	Gastroplasty w/o v-band
43845	Gastroplasty duodenal switch
43846	Gastric bypass for obesity
43847	Gastric bypass incl small i
43848	Revision gastroplasty
43886	Revise gastric port open
43887	Remove gastric port open
43888 S2083	Change gastric port open Adjustment of gastric band diameter

Limits

1) Members who have a history of severe psychiatric disturbance (schizophrenia, borderline personality disorder, suicidal ideation, severe depression) or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic medications, a pre-operative psychological evaluation and clearance is necessary in order to exclude members who are unable to provide informed consent or who are unable to comply with the pre- and postoperative regimen.
2) Surgery to correct complications from bariatric surgery, such as obstruction or stricture, wound infections or hernias is covered only when the original bariatric surgery was (is) eligible for coverage.
3) Obesity surgery for members under 18 is not covered as the safety and effectiveness have not been adequately documented 1
4) Any of the following procedures are considered experimental and investigational because the peer reviewed medical literature shows them to be either unsafe or inadequately studied:
   a) Loop gastric bypass
   b) Gastroplasty, more commonly known as “stomach stapling” (see below for clarification from vertical band gastroplasty)
   c) Duodenal switch operation
   d) Biliopancreatic bypass (Scopinaro procedure)
   e) Mini gastric bypass
   f) Silastic ring vertical gastric bypass (Fobi pouch)
   g) Intragastric balloon
   h) VBG, except in limited circumstances noted above.

Background

1) Morbid obesity occurs in up to five percent of the U.S. population and the prevalence is increasing. Obesity is an increase in body weight beyond the limitation of skeletal and physical requirements, as a result of an excessive accumulation of fat in the body. In general, 20% to 30% above "ideal" body weight, according to standard life insurance tables, constitutes obesity. Morbid obesity is further defined as a condition of consistent and uncontrollable weight gain that is characterized by a weight which is at least 100 lbs. or 100% over ideal weight and/or a body mass index (BMI) of 40 or greater (35 if comorbid conditions are present). The highest risk for complications of obesity occurs with a BMI of >40. Comorbid conditions include osteoarthritis, sleep apnea, restrictive pulmonary disease, diabetes, cardiac disease and hypertension. Surgery alone is not adequate for long-term management. It must be provided in conjunction with a long-term dietary and activity management program in a multidisciplinary setting. However, diet and activity programs, even with behavioral therapy, are rarely successful alone in achieving weight reduction goals for the morbidly obese person.

2) The patient`s ability to lose some weight prior to surgery makes surgical intervention easier and also provides an indication of the likelihood of compliance with the severe dietary restriction imposed on patients following surgery.

3) Given the importance of patient compliance on diet and self-care in improving patient outcomes after surgery, the patient`s refusal to even attempt to comply with a nutrition and exercise regimen prior to surgery portends poor compliance with nutritional and self-care requirements after surgery. Therefore, the appropriateness of obesity surgery in noncompliant patients should be questioned.

4) The patient must be committed to the appropriate work-up for the procedure and for continuing long-term postoperative medical management, and must understand and be adequately prepared for the potential complications of the procedure.

5) There is rarely a good reason why obese patients (even super obese patients) cannot delay surgery in order to undergo behavior modification to improve their dietary and exercise habits in order to reduce surgical risks and improve surgical outcomes. The patient may be able to lose significant weight prior to surgery in order to improve the outcome of surgery.

Reference

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17) Centers for Medicare and Medicaid Services (CMS). Decision memo for bariatric surgery for the treatment of morbid obesity (CAG-00250R). Medicare Coverage Database. Baltimore, MD: CMS; February 21, 2006. Available at: www.cms.hhs.gov.

Addendum:
Effective 06/01/2023: Updated evaluation criteria to not be exclusive to a psychiatrist.

Application to Products
This policy applies only to the Federal Employees Health Benefits Program Federal Employees Health Benefits Program medical plan – groups 27030 and 27130. For any other group number see policy BI 158.

Changes: QualChoice reserves the right to alter, amend, change or supplement benefit interpretations as needed.