

SURGICAL TREATMENT OF OBESITY

Effective Date: October 31, 2022

Review Dates: 8/11, 12/11, 2/12, 2/13, 2/14, 11/14,
2/15, 2/16, 2/17, 2/18, 5/18, 5/19, 8/19, 5/20, 5/21,
2/22, 5/22, 8/22

Date Of Origin: August 10, 2011

Status: Current

Note: This medical policy does not apply to Priority Health Medicare members. Medicare claim billing and processing must follow CMS guidelines for coverage.

Summary of Changes

Additions:

- I. A. 3. d.: Specified requirements for the scope of the pre-surgical psychosocial evaluation.

Changes:

- I. A. 3. e. v.: Note now reads: *For members who have a **diagnosed substance use disorder**, there must be documented compliance with abstinence, including negative monthly urine drug screens for at least six continuous months.*

I. POLICY/CRITERIA

A. Criteria 1-4 must be met to be considered for Primary Bariatric Surgical (PBS) and Revisional Bariatric Surgical (RBS) treatment of obesity:

1. Age > 18 years and the surgery must be performed by a surgeon who is a regular member in good standing of the American Society for Metabolic and Bariatric Surgery (ASMBS).
2. Prior approval must be obtained for Bariatric Surgery.
3. A pre-operative care and evaluation must occur in which all of the following must be met:
 - a. Complete medical evaluation by PCP or other physician.
 - b. Evidence that all other alternatives have been discussed with and offered to patient, and that all reasonable non-surgical options have been attempted.
 - c. Documentation of active participation in and compliance with a medical weight management program, when applicable**, provided by a credentialed physician with a declared interest in the management of obesity, the member's primary care physician (PCP) or other managing physician as outlined in the *Medical Management of Obesity policy #91594*. The medical weight management program must include all of the following:

- i. Documentation of active participation and compliance with a medical weight management program for a minimum continuous duration of 6 months* with at least 6 office visits including both a diet and exercise component and in which the obesity and weight-related conditions (i.e. diabetes, hypertension and hyperlipidemia) are being addressed.

*Priority Health Medicaid and Commercial Individual products require compliance with a medical weight management program for a minimum continuous duration of 12 months and at least 12 office visits.

- ii. Thorough progress notes and records that include the following regarding the obesity problem at each visit:
 - a) An actual measured weight and calculated BMI
 - b) The patient's history
 - c) The physical findings
 - d) The physician's assessment
 - e) The physician's treatment recommendation(s)/plan(s).

The medical weight management program must be completed within two years of the request for surgery.

All documentation in #3 above should be submitted with the request for Bariatric Surgery. The reported BMI should be based upon measurement of height and weight within one month of beginning the medical weight management program.

Please use the link below to access templates that demonstrate the required documentation. These forms may be used in conjunction with the medical record to document the physician directed weight management program.

<https://www.priorityhealth.com/provider/manual/forms/medical-device-auth-forms>

**Criterion 3c for at least 6 months medical management (12 months for Priority Health Medicaid and Commercial Individual products). This does not apply if BMI is ≥ 50 .

The Medical Director will review each such case on an individualized basis to determine compliance with this policy section.

Past weight loss attempts without physician supervision through programs such as Weight Watchers, Curves, personal trainers, etc. are insufficient to meet this criterion.

- d. A comprehensive psychosocial evaluation* conducted by a licensed behavioral specialist. It is recommended that this evaluator possess knowledge, experience, and training relevant to obesity, eating disorders, and weight loss surgery.

This evaluation must establish the patient's:

- Emotional stability
- Ability to comprehend the risks of surgery and to give informed consent
- Ability to cope with expected post-surgical lifestyle changes and limitations.

*Note: Psychosocial evaluation must include presurgical psychosocial domains as recommended by the American Society for Metabolic and Bariatric Surgery and the American Psychiatric Association (for example, [Bariatric Presurgical Psychosocial Evaluation Form](#)). Evaluation must include substance use history with required statement as to whether substance use resulted in maladaptive behavior or is considered prohibitive to bariatric surgery.

- e. None of the following medical conditions is present:
- i. Pregnancy/lactation.
 - ii. Severe psychopathology.

Note: For members who have severe psychopathology who are currently under the care of a psychiatrist, or who are on psychotropic medications, preoperative psychiatry clearance is necessary in order to determine informed consent and an ability to comply with pre- and post-operative regimen.

- iii. Medical condition that makes patient a prohibitive risk.
- iv. Any disease (e.g. cancer, uremia, liver failure), associated with a likelihood of survival less than 1 year.
- v. Substance abuse including alcohol and other drugs of abuse.

Note: For members who have a diagnosed substance use disorder, there must be documented compliance with abstinence, including negative monthly urine drug screens for at least six continuous months.

vi. Tobacco use.

Note: For members that have a current history of smoking or smoking within the past two years, documented compliance demonstrating smoking cessation, including two biomarker verification tests (e.g. urine screen for concentration of nicotine and related metabolites and alkaloids) within a 30-day time period, is required. These levels must be taken no earlier than 6 weeks prior to requesting Bariatric Surgery.

4. Weight criteria – Member **must** meet “a” or “b” or “c”:
- a. BMI \geq 35: participation in medical weight management program, and at least one of the following life-endangering obesity-related co-morbidities:
 - i. Symptomatic obstructive sleep apnea unresponsive to conservative treatment (e.g., C-Pap), with evidence of right ventricular hypertrophy (RVH).
 - ii. Significant atherosclerotic cardiovascular disease (e.g. right ventricular hypertrophy (RVH), left ventricular hypertrophy (LVH), arteriosclerotic heart disease (ASHD)).
 - iii. **Resistant hypertension:** Uncontrolled blood pressure (greater than 140 mm Hg systolic and/or 90 mm Hg diastolic) despite the concurrent use of 3 or more antihypertensive agents of different classes at maximal or maximally tolerated doses.
 - iv. **Poorly controlled type 2 diabetes mellitus**, as evaluated by a specialist with specific expertise in diabetes.
 - v. **Congestive heart failure (CHF)** Class III or IV.

Note: Hyperlipidemia, gastroesophageal reflux disease (GERD), and degenerative joint disease do NOT qualify as they are NOT considered life endangering.

- b. BMI \geq 40: A co-morbidity is not required. However, participation in a medical weight management program is required.
- c. BMI \geq 50: Neither a co-morbidity, nor participation in a medical weight management program, is required.

B. Limitations

1. The following bariatric procedures are covered when the surgical criteria above have been met:
 - a. Roux-en-Y gastrojejunostomy
 - b. Laparoscopically Adjustable Banding with FDA approved device
 - c. Biliopancreatic Diversion with Duodenal Switch (BPD/DS)
 - d. Sleeve gastrectomy
2. For components of the medical weight management program please see the *Medical Management of Obesity Medical Policy #91594*.
3. Coverage for medical and surgical programs is limited by applicable copays, coinsurance and deductibles.
4. Other bariatric procedures, including but not limited to the following, are not covered:
 - a. Gastric banding with devices that are not FDA approved
 - b. Gastric balloon and space occupying devices (e.g. Orbera, Reshape Duo)
 - c. Other intestinal bypass procedures
 - d. Mini-gastric bypass
 - e. Endoscopic revision of bariatric surgery, including the ROSE™ (Revision Obesity Surgery, Endoscopic) and Stomaphyx™ procedures.
 - f. Vagal Blocking for Obesity Control (e.g. VBLOC, Maestro Rechargeable System)
 - g. AspireAssist device
5. Coverage for Medicaid/Healthy Michigan Plan members is limited to one bariatric surgery per lifetime. Unless Medically/Clinically Necessary (see Corrective Revisional Bariatric Surgery - Section I, C, 2, a-c below), a second bariatric surgery is **not** Covered, even if the initial bariatric surgery occurred prior to Coverage under this plan.
6. The adjustable silicone gastric banding (LAP-Band) was reviewed by Priority Health's Technology Assessment Committee (TAC) in September 2003, December 2003, March 2005 and June 2005 and this policy reflects recommendations of the TAC. Biliopancreatic Diversion with Duodenal Switch was reviewed by Priority Health's Technology Assessment Committee in March 2006 and this policy reflects recommendation of the TAC. Endoscopic revision of bariatric surgery was reviewed by Priority Health's Technology Assessment Committee in December 2007 and this policy reflects the recommendation of TAC.

C. Revisional Bariatric Surgery (RBS):

Revisional Bariatric Surgery (RBS) includes Conversion RBS (PBS to second procedure), or Corrective RBS (to treat complications of PBS).

1. Conversion Revisional Bariatric Surgery (Conversion RBS):

- a. In members whose primary bariatric surgery (PBS) was Roux-en-Y gastric bypass (RYGB), vertical sleeve gastrectomy (VSG), or biliopancreatic diversion with duodenal switch (BPD-DS) or without duodenal switch (BPD), Conversion RBS is medically necessary in patients who continue to meet medical necessity criteria for PBS (as in I.A. above), and who meet all of the following medical necessity criteria:
 - i. Conversion to a sleeve gastrectomy, RYGB or BPD/DS is considered medically necessary for members who have not had adequate success (defined as loss of more than 50% of excess body weight) 2 years following the primary bariatric surgery (PBS) procedure.
 - ii. The member has been compliant with a prescribed nutrition and exercise program following the procedure as evidenced by clinical documentation and nutrition counseling to verify report of inability to eat appropriate foods and calorie due to persistent symptoms (pain, nausea, emesis).
- b. In members whose primary bariatric surgery (PBS) was an adjustable gastric band (AGB), Conversion RBS is medically necessary for members who continue to meet medical necessity criteria for PBS (as in I.A. above), and who meet all of the following medical necessity criteria:
 - i. Conversion to a sleeve gastrectomy, RYGB or BPD/DS is considered medically necessary in members who have not had adequate success (defined as loss of more than 50% of excess body weight) 2 years following the primary bariatric surgery (PBS) procedure.
 - ii. The member has been compliant with a prescribed nutrition and exercise program following the procedure as evidenced by clinical documentation and nutrition counseling to verify report of inability to eat appropriate foods and calories due to persistent symptoms (pain, nausea, emesis).
 - iii. There are complications that cannot be corrected with band manipulation, adjustments or removal.

2. Corrective Revisional Bariatric Surgery (Corrective RBS):

- a. In members whose primary bariatric surgery (PBS) was Roux-en-Y gastric bypass (RYGB), vertical sleeve gastrectomy (VSG), or

biliopancreatic diversion with duodenal switch (BPD-DS) or without duodenal switch (BPD), Corrective RBS is considered medically necessary to correct acute or chronic mechanical and or anatomic complications including fistula, obstruction, stricture, marginal ulcer, if the above results in abdominal pain, inability to eat or drink or causes persistent vomiting of prescribed meals.

- b. In members whose primary bariatric surgery (PBS) was an adjustable gastric band (AGB), Corrective RBS including manipulation, adjustments, repair or removal is considered medically necessary if there are complications (e.g., port leakage, slippage, erosion) resulting in inability to eat appropriate foods due to persistent symptoms.
- c. In members whose primary bariatric surgery (PBS) was vertical sleeve gastrectomy (VSG), or biliopancreatic diversion with duodenal switch (BPD-DS) or without duodenal switch (BPD), or adjustable gastric band (AGB), Corrective RBS with Roux-en-Y gastric bypass (RYGB) or BDP-DS, is considered medically necessary for persistent gastroesophageal reflux disease unresponsive to medical therapy for members who continue to meet the criteria in I.A. above.

D. Not Medically Necessary:

- 1. Poor response to Primary Bariatric Surgery due to patient post-operative behavior (not following dietary restriction, large portion meals, lack of documented exercise) does not constitute a surgical complication and the revision of this condition is considered **not medically necessary**.
- 2. PBS and RBS will frequently ameliorate symptoms of co-morbidities such as diabetes, gastroesophageal reflux disease and obstructive sleep apnea. However, the purpose of bariatric surgery in obese persons is to achieve weight loss. Therefore, coverage would not exist for bariatric surgery to treat co-morbidities caused or exacerbated by obesity unless in accordance with the limitations and language as above.

E. SPECIAL NOTES

Specific group benefit plans may require coverage for the medical or surgical treatment of obesity beyond the coverage set forth in this policy.

II. MEDICAL NECESSITY REVIEW

Required Not Required Not Applicable

III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.*
- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*
- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.*
- ❖ **MEDICAID/HEALTHY MICHIGAN PLAN:** *For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.*

IV. DESCRIPTION

Surgical treatment for obesity may be a covered benefit for the indications described above. The treatment of co-morbidities (e.g. diabetes mellitus, hypertension) associated with obesity is a covered benefit in accordance with the limitations and language in the coverage documents. It is Priority Health's position that co-morbidities that are related to an obesity diagnosis should be treated medically, and if such co-morbidities can be controlled by less invasive means than bariatric surgery, bariatric surgery is not the preferred treatment.

All surgical services for weight management require prior authorization.

The Aspire Assist (Aspire Bariatrics) device: To place the device, surgeons insert a tube in the stomach with an endoscope via a small incision in the abdomen. A disk-shaped port valve that lies outside the body, flush against the skin of the abdomen, is connected to the tube and remains in place. Approximately 20 to 30 minutes after meal consumption, the patient attaches the device's external connector and tubing to the port valve, opens the valve and drains the contents. Once opened, it takes approximately five to 10 minutes to drain food matter through the tube and into the toilet. The device removes approximately 30 percent of the calories consumed. In a clinical trial of 111 patients treated with Aspire

Assist and appropriate lifestyle therapy, and 60 control patients who received only the lifestyle therapy, patients using Aspire Assist lost an average of 12.1 percent of their total body weight compared to 3.6 percent for the control patients after one year.

Tobacco use (e.g. cigarettes, pipe, cigar, chew etc.) is a contraindication to surgery. Nicotine and its metabolites are biomarkers that can be tested to distinguish active tobacco use from passive exposure. Cotinine, a nicotine metabolite, is commonly used in tobacco cessation testing because it has a longer half-life than nicotine and can be tested in urine, plasma, or serum. Tobacco products also contain alkaloids such as anabasine and nornicotine which can be tested to distinguish between use of tobacco products and nicotine replacement therapies. Anabasine is present in tobacco products, but not nicotine replacement therapies. The presence of nornicotine without anabasine is consistent with use of nicotine replacement products. Neither anabasine nor nornicotine accumulates from passive exposure. Urine testing is recommended over serum or plasma testing because it is less invasive and analytes are detectable for a longer period of time. There are no optimal cut-off values for cessation testing; urinary cotinine thresholds may vary between 10-50 ng/ml, and in general the presence of anabasine greater than 10 ng/mL or nornicotine greater than 30 ng/mL in urine indicates current tobacco use. In addition, reference ranges may vary by laboratory. The laboratory's threshold should be used to determine if there is a positive or negative indication of tobacco use.

Psychosocial optimization

A **preoperative psychosocial evaluation/assessment**, conducted by a qualified behavioral health clinician with relevant specialized knowledge, is recommended by professional societies and is required by many third-party payors. While these evaluations may identify clear contraindications for surgery, the psychosocial evaluation is best conceptualized as a way to identify strengths and vulnerabilities and develop recommendations to enhance surgical outcome. Because long-term outcome is substantially influenced by patient behaviors, it follows that preoperative psychosocial optimization is important for all patients, not solely those with a history of psychopathology.

The American Society for Metabolic and Bariatric Surgery (ASMBS) recommends that the **presurgical psychosocial evaluation** of bariatric surgery patients address the following domains:

- Weight history
- Eating disorder symptoms (including maladaptive eating patterns)
- Psychosocial history, including:
 - Psychiatric history and psychosocial functioning
 - Developmental and family history
 - Current and past mental health treatment
 - Cognitive functioning

- Personality traits and temperament
- Current stressors
- Social support
- Quality of life
- Health-related behaviors, including:
 - Substance use
 - Smoking
 - Adherence
 - Physical activity
- Patient motivation and knowledge, including:
 - Weight loss expectations
 - Motivation
 - Knowledge of surgical procedures, risks, and benefits

While **drug abuse** is no longer a current medical diagnosis in either of the most used diagnostic tools in the world (the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), and the World Health Organization's International Classification of Diseases (ICD)), the [National Cancer Institute](#) defines **drug abuse** as follows: *The use of illegal drugs or the use of prescription or over-the-counter drugs for purposes other than those for which they are meant to be used, or in excessive amounts. Drug abuse may lead to social, physical, emotional, and job-related problems. The more appropriate, currently accepted term is **substance use disorder (SUD)**.*

A **substance use disorder (SUD)** is a medical condition that is defined by the inability to control the use of a particular substance (or substances) despite harmful consequences. In other words, SUDs occur when an individual compulsively misuses drugs or alcohol and continues abusing the substance despite knowing the negative impact it has on the individual's life.

The **American Psychiatric Association (APA)** has developed 11 criteria for SUD diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5):

- Taking the substance for long periods of time or in larger amounts than intended.
- Being unable to cut down or stop substance use.
- Spending a lot of time obtaining, using, and recovering from the effects of the substance.
- Experiencing cravings, or intense desires or urges for the substance.
- Failing to fulfill obligations at home, work, or school due to substance use.
- Continuing substance use despite having interpersonal or social problems that are caused or worsened by substance use.
- Giving up social, recreational, or occupational activities due to substance use.

- Using the substance in risky or dangerous situations.
- Continuing substance use despite having a physical or mental problem that is probably due to substance use.
- Tolerance, or needing more of the substance to achieve previous effects.
- Withdrawal, meaning that unpleasant symptoms occur when once stops using one's substance of choice.

SUDs may range from mild to severe, with severity depending on the number of symptoms/diagnostic criteria a person meets:

- **Mild:** displays 2-3 symptoms/criteria,
- **Moderate:** displays 4-5 symptoms/criteria, and
- **Severe:** displays 6 or more symptoms/criteria.

V. CODING INFORMATION

ICD-10 Codes that *may* support medical necessity:

E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug-induced obesity
E66.2	Morbid (severe) obesity with alveolar hypoventilation
E66.8	Other obesity
E66.9	Obesity, unspecified

The following codes may be reported as secondary Dx only

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) 50-59.9, adult
Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.45	Body mass index (BMI) 70 or greater, adult

CPT/HCPCS Codes:

**No Prior auth required for these procedures*

43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components)
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, surgical, gastric restrictive procedure; removal of adjustable gastric band and subcutaneous port components
- 43775 Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)

- 43845 Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
- 43846 Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy

- 43848 Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric band (separate procedure)
- 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

- S2083* Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline

- 43999 Unlisted procedure, stomach (*Explanatory notes must accompany claim*)
Use this code for billing: Open sleeve gastrectomy

Lab test for tobacco cessation verification (subject to drug testing limits; See *policy 91611 Drug Testing*)

- 80307* Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
- 80323* Alkaloids, not otherwise specified (*Not Covered for Medicare, use G code*)
- G0480* Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all

sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed

Not covered:

- 43647 Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
- 43648 Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum

- 43842 Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
- 43843 Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
- 43847 Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption

- 43881 Implantation or replacement of gastric neurostimulator electrodes, antrum, open
- 43882 Revision or removal of gastric neurostimulator electrodes, antrum, open

The unlisted codes below are not covered when billed for the following conditions:

- Balloon Gastroplasty
- Endoscopic revision of bariatric surgery
- Open gastric band
- Laparoscopic vertical banded gastroplasty
- Open sleeve gastrectomy (*Not covered for Priority Health Medicare*)
- (*Explanatory notes must accompany claims billed with unlisted codes.*)

- 43659 Unlisted laparoscopy procedure, stomach
- 43999 Unlisted procedure, stomach

- 0312T Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming
- 0313T Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator
- 0314T Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator
- 0315T Vagus nerve blocking therapy (morbid obesity); removal of pulse generator
- 0316T Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator
- 0317T Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed

BODY MASS INDEX (BMI) CHART

--	--	--	--	--	--	--	--	--	--	--

Height Weight	4'8"	4'10"	5'0"	5'2"	5'4"	5'6"	5'8"	5'10"	6'0"	6'2"	6'4"
150	34	31	29	27	26	24	23	22	20	19	18
160	36	33	31	29	27	26	24	23	22	21	19
170	38	36	33	31	29	27	26	24	23	22	21
180	40	38	35	33	31	29	27	26	24	23	22
190	43	40	37	35	33	31	29	27	26	24	23
200	45	42	39	37	34	32	30	29	27	26	24
210	47	44	41	38	36	34	32	30	28	27	26
220	49	46	43	40	38	36	33	32	30	28	27
230	52	48	45	42	39	37	35	33	31	30	28
240	54	50	47	44	41	39	36	34	33	31	29
250	56	52	49	46	43	40	38	36	34	32	30
260	58	54	51	48	45	42	40	37	35	33	32
270	61	56	53	49	46	44	41	39	37	35	33
280	63	59	55	51	48	45	43	40	38	36	34
290	65	61	57	53	50	47	44	42	39	37	35
300	67	63	59	55	51	48	46	43	41	39	37
310	69	65	61	57	53	50	47	44	42	40	38
320	72	67	62	59	55	52	49	46	43	41	39
330	74	69	64	60	57	53	50	47	45	42	40
340	76	71	66	62	58	55	52	49	46	44	41
350	78	73	68	64	60	56	53	50	47	45	43
360	81	75	70	66	62	58	55	52	49	46	44
370	83	77	72	68	64	60	56	53	50	48	45
380	85	79	74	69	65	61	58	55	52	49	46
390	87	82	76	71	67	63	59	56	53	50	47
400	90	84	78	73	69	65	61	57	54	51	49

	Normal	Overweight	Obesity (Class I)	Obesity (Class II)	Extreme Obesity
BMI	19-24	25-29	30-34	35-39	40-45

BMI, a weight and height ratio, is often used to diagnose obesity by approximating body fat level. The National Institutes of Health and the World Health Organization have determined that a healthy BMI is between 18.6 and 24.9. BMI between 25.0 and 29.9 indicates an individual is overweight and a BMI greater than 30 indicates obesity.

Among children and adolescents, the Centers for Disease Control and Prevention (CDC) use the term “overweight” if the child is $\geq 85^{\text{th}}$ percentile of BMI and “obese” as the group $\geq 95^{\text{th}}$ percentile of BMI.

To calculate BMI: BMI = Weight (kilogram) divided by Height (meter) squared [(w/h²) or (kg/m²)]

Note: To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254.

INDICATOR OF TOBACCO USE

	Tobacco Product User	Nicotine Replacement Product User	Non-tobacco user with passive exposure	Non-tobacco user with no passive exposure
Nicotine	+	+	+	-
Cotinine	+	+	+	-
Anabasine	+	-	-	-
Nornicotine	+	+	-	-

VI. REFERENCES

- Acelajado MC, et al. Treatment of Resistant and Refractory Hypertension. *Circulation Research*. 2019; 124:1061–1070. Originally published 28 Mar 2019 <https://doi.org/10.1161/CIRCRESAHA.118.312156>.
- Obesity Surgery. Clinical Policy Bulletin 0157. Aetna. http://www.aetna.com/cpb/medical/data/100_199/0157.html. (Retrieved April 2018; March 25, 2019; March 25, 2021).
- Bariatric Surgery and Procedures. Coverage Policy Number 0051. Cigna. https://static.cigna.com/assets/chcp/pdf/coveragePolicies/medical/mm_0051_coveragepositioncriteria_bariatric_surgery.pdf (Retrieved march 25, 2021).
- Carter J, et al. [ASMBS position statement on preoperative patient optimization before metabolic and bariatric surgery](#). *Surgery for Obesity and Related Diseases* (2021) 1–21.
- Delko T, Köstler T, Peev M, Esterman A, Oertli D, Zingg U. Revisional versus primary Roux-en-Y gastric bypass: a case matched analysis. *Surg Endosc*. 2014;28:552-558.
- FDA News Release FDA approves AspireAssist obesity device, June 14, 2016 @ <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm506625.htm>
- Hasin DS, O'Brien CP, Auriacombe M, et al. [DSM-5 criteria for substance use disorders: recommendations and rationale](#). *Am J Psychiatry*. 2013;170(8):834-851. doi:10.1176/appi.ajp.2013.12060782
- Hayes, Inc. Revisional Surgery for Treatment of Complications After Bariatric Surgery. July 24, 2014. (Annual Review July 10, 2017).
- Hayes, Inc. Intra-gastric Balloons for Treatment of Obesity. Medical Technology Directory. March 29, 2018.
- Hayes, Inc. Impact of Preoperative Supervised Weight Loss Programs on Bariatric Surgery Outcomes. Medical Technology Directory. December 19, 2017.
- Kim, JJ, et al. American Society for Metabolic and Bariatric Surgery updated position statement on insurance mandated preoperative weight loss requirements. *Surgery for Obesity and Related Diseases*.12 (2016) 955–959.
- Mechanick JI, et al. Clinical Practice Guidelines for the Perioperative Nutritional, Metabolic, and Nonsurgical Support of the Bariatric Surgery Patient—2013 Update: Cosponsored by American Association of Clinical

- Endocrinologists, The Obesity Society, and American Society for Metabolic & Bariatric Surgery. *Surgery for Obesity and Related Diseases*. 9 (2013) 159-191.
- Mor A, Keenan E, Portenier D, Torquati A. Case-matched analysis comparing outcomes of revisional versus primary laparoscopic Roux-en-Y gastric bypass. *Surg Endosc*. 2013;27(2):548-552.
- Moyer TP et al. Simultaneous Analysis of Nicotine, Nicotine Metabolites, and Tobacco Alkaloids in Serum or Urine by Tandem Mass Spectrometry, with Clinically Relevant Metabolic Profiles. *Clinical Chemistry*. 2002; 48(9): 1460-1471.
- Parikh M, et al. American Society for Metabolic and Bariatric Surgery position statement on alcohol use before and after bariatric surgery. *Surgery for Obesity and Related Diseases*. 12 (2016) 225-230.
- Radtko JF III, Puleo FJ, Wang L, Cooney RN. Revisional bariatric surgery: who, what, where, and when? *Surg Obes Relat Dis*. 2010;6(6):635-642.
- Slegtenhorst BR, van der Harst E, Demirkiran A, de KJ, Schelfhout LJ, Klaassen RA. Effect of primary versus revisional Roux-en-Y gastric bypass: inferior weight loss of revisional surgery after gastric banding. *Surg Obes Relat Dis*. 2013;9(2):253-258.
- Sogg S, et al. **Recommendations for the presurgical psychosocial evaluation of bariatric surgery patients. American Society for Metabolic and Bariatric Surgery Guideline/Statement.** *Surgery for Obesity and Related Diseases*. 12 (2016) 731-749.
- Topart P, Becouarm G, Ritz P. One-year weight loss after primary or revisional Roux-en-Y gastric bypass for failed adjustable gastric banding. *Surg Obes Relat Dis*. 2009;5(4):459-462.
- Whelton PK, et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA guideline for the prevention, detection, evaluation, and management of high blood pressure in adults: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Circulation*. 2018;138:e484–e594. DOI: 10.1161/CIR.0000000000000596.
- Zingg U, McQuinn A, DiValentino D, Kinsey-Trotman S, Game P, Watson D. Revisional vs. primary Roux-en-Y gastric bypass--a case-matched analysis: less weight loss in revisions. *Obes Surg*. 2010;20(12):1627-1632.

AMA CPT Copyright Statement:

All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

This document is for informational purposes only. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion.

Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

The name "Priority Health" and the term "plan" mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.