Coverage Guidelines

Bariatric Surgery for Morbid Obesity
(Open or Closed)

Disclaimer:
Please note that Baptist Health Plan Coverage Guidelines may be updated throughout the year. A printed version may not be most up to date version available. The health plan reserves the right to review and update this policy as needed. Refer to the website to ascertain that you are utilizing the most current available version. Clinical guideline policies are not intended to serve as treatment guidelines or treatment recommendation. Treating providers must use their own clinical judgment in rendering care to their patient population.

DEFINITION

Surgery for obesity may produce weight loss by either limiting the amount of food the stomach can hold (a restrictive procedure), or by creating a small stomach pouch and bypassing part of the small intestine to limit the food that is absorbed by the body (a restrictive/malabsorptive procedure).1

Types of restrictive procedures include:

- Laparoscopic adjustable gastric banding (LAGB): the placement of a hollow band around the upper end of the stomach, creating a small pouch and a narrow passage into the larger remainder of the stomach. The band is inflated with a saline solution, which can be increased or decreased over time to alter the size of the passage.
- Laparoscopic gastric plication: the creation of a smaller stomach pouch by folding and sewing the stomach.
- Natural orifice transluminal endoscopic surgery (NOTES): incisionless surgeries performed with an endoscope passed through the mouth.
- Vertical banded gastroplasty (VBG): removal of stomach tissue and the use of a band and staples to create a small stomach pouch.

Types of restrictive/malabsorptive procedures include:

- Biliopancreatic diversion (BPD) with or without duodenal switch (DS): partial resection of the stomach while most proximal areas of the small intestine are bypassed. BPD with DS leaves a larger portion of the stomach intact, including the pyloric valve that regulates the release of stomach contents into the small intestine.
- Mini gastric bypass (MGB): the jejunum is attached directly to the stomach.
- Roux-en-Y gastric bypass (RYGB): is the most common and successful malabsorptive
surgery and is generally known as gastric bypass. A small stomach pouch is created to restrict food intake. The rest of the stomach is bypassed via a Y-shaped segment of the small intestine. In long-limb RYGB, the limb through which food passes is longer and is often used to treat super obese individuals.

- Sleeve gastrectomy: the removal of the greater curvature of the stomach and approximately 80 percent of the stomach volume.
- Vagal blocking for obesity control (VBLOC): laparoscopic placement of two electrodes in contact with vagal nerve trunks and a subcutaneously implanted neuromodulation device which is intermittently send electrical impulses via the implanted electrodes. The electrical impulses are purported to block vagus nerve signals in the abdominal region, inhibiting gastric motility and increasing satiety.

Surgery for obesity can be performed using laparoscopes (done with the help of endoscopes through several small incisions) or by laparotomy (the surgical opening of the abdomen). Laparoscopic procedures are referred to as “closed” procedures. Laparotomy is referred to as an “open” procedure.

Laparoscopic gastric bypass is a safe and cost effective alternative to open gastric bypass. Even though the operative time is longer, patients benefit from less blood loss, a shorter hospital stay, and faster convalescence while achieving weight losses comparable to patients undergoing open procedures. Most bariatric surgeries are now performed laparoscopically.

### COVERAGE CRITERIA

**NOTE:** Most Baptist Health Plan Certificates of Coverage (COC) exclude or limit any treatment for obesity regardless of medical necessity. This includes: weight reduction programs, surgery, drugs, removal of excess fat or skin following weight loss due to obesity, surgery, or pregnancy; services at a health spa or similar facility; services, supplies, or other care for gastric bubble/gastric balloon procedures, stomach stapling, wiring of the jaw, liposuction, and jejunal bypasses; and/or dietary supplements, diet pills, and appetite suppressants.

Treatment of complications resulting from an excluded/limited procedure or treatment is excluded by the Certificate of Coverage.

If the member’s Certificate of Coverage provides benefits, for the treatment of obesity, Bariatric surgery as a means to resolve or alleviate serious obesity related comorbidities involving abnormal glucose metabolism such as type 2-diabetes, is considered medically necessary at the discretion of Baptist Health Plan Insurance.

Bariatric surgery coverage is limited to self-insured groups only.

If the member’s Certificate of Coverage provides benefits for the treatment of obesity, those benefits are plan-specific to self-funded groups and must satisfy the criteria for medical necessity. The following bariatric surgical procedures are proven in adults for the treatment of clinically severe obesity:

- Laparoscopic Adjustable Silicone Gastric Banding (LASGB)
- Open or laparoscopic Biliopancreatic diversion (BPD) with or without duodenal switch (DS)
- Open or laparoscopic short or long-limb Roux-en-Y gastric bypass (RYGB)
• Open or laparoscopic sleeve gastrectomy
• Open or laparoscopic Vertical banded gastroplasty (VBG)

Bariatric surgery using one of the procedures identified above is **medically necessary** when all of the following criteria are met:

- Member is morbidly obese as documented in prior medical records by the primary care physician, and satisfies the criteria below:
  - Has a Body Mass Index (BMI) of 40 or higher, or
  - Has a BMI of 35 or higher with at least one of the following comorbidities:
    - Hypertension, or
    - Type II diabetes, or
    - Life threatening cardio-pulmonary problems, (for example, severe obstructive sleep apnea, Pickwickian syndrome, obesity related cardiomyopathy),

- Member’s primary care physician can provide documentation of failure to lose weight in a structured weight loss program for a minimum of 6-months in the two years prior to surgery with no specific cause for obesity that is medically correctable, such as hypothyroidism, Cushing’s syndrome, or an endocrine disorder

- Member is over 18 years of age
- Member is in good health except for obesity associated with any of the criteria listed above, with professionally documented evidence of emotional stability. Documented evidence is confirmation from the physician requesting authorization for the surgery that there are no psychological contraindications to the proposed surgery, or that such contraindications have been resolved for at least one year.

**Repeat bariatric surgery** is medically necessary when:

- There is documentation of a surgical complication related to the original surgery, such as a fistula, obstruction, erosion, disruption/leakage of a suture/staple line, band herniation, or pouch enlargement due to vomiting.

- There is inadequate weight loss or weight regain* after a covered primary bariatric surgery and there is documentation of compliance with the previously prescribed postoperative dietary and exercise program while the member continues to meet all the medical necessity criteria for bariatric surgery.

  * Two years following the original surgery, weight loss is less than 50% of pre-operative excess body weight and weight remains at least 30% over ideal body weight.

Requests for outpatient revision of these procedures will **not** be considered without adequate documentation from the requesting physician of the member’s inability to maintain weight loss after surgery despite compliance in the post-surgical management program, and without adequate documentation of continuing adherence to dietary restrictions and physical activity. Physicians requesting a revision of a gastric restrictive procedure for a morbidly obese member must provide documentation of failure secondary to a surgical complication such as a fistula, obstruction, or disruption of a suture/staple line.
Excess Skin Removal:
(Please note that this section applies only to plans that include this benefit by contract. Refer to the member’s individual certificate as not all plans that cover bariatric surgery cover excess skin removal) Surgical procedures for removal of excess skin and/or fat at each body site resulting from excessive weight loss from bariatric surgery or rapid weight loss without surgery is considered medically necessary if ALL of the following are met:

- The excess skin is **significant** as documented by pictures AND
- The excess skin is the primary cause of skin condition complications such as cellulitis, transdermal skin ulcerations, and/or fungal infections AND
- The skin condition is ongoing and chronic (more than 3 months) AND
- The skin condition has been resistant to conservative treatment (including but not limited to antibiotics and fungal medication) AND
- All conservative treatment options performed are well documented in the medical records

**IN ADDITION, the weight loss must be stable, be maintained for at least 6 months, and if surgery was performed, be at least 12-18 months following surgery.**

The bariatric surgical procedures listed below are NOT currently considered medically necessary or are considered experimental/investigational due to the paucity of available peer-reviewed, randomized, controlled, published evidence assessing these surgeries:

- Open adjustable gastric banding
- Vagus/vagal nerve blocking, VBLOC (e.g., Maestro)
- Laparoscopic mini gastric bypass
- Laparoscopic gastric plication with or without Gastric banding
- Natural orifice transluminal endoscopic surgery (NOTES) such as Endoscopic duodenal-jejunal bypass, Intragastric balloon, Restorative obesity surgery, endoluminal (ROSE) procedure, Transoral gastroplasty (TG), and any endoscopic closure device (Over the Scope clip [OTSC] system set, OverStitch endoscopic suturing system, StomaphyX endoluminal fastener and delivery system) in conjunction with NOTES

**Bariatric surgery for morbid obesity will NOT BE CONSIDERED MEDICALLY NECESSARY for:**

1. Members whose Certificate of Coverage excludes treatment of obesity
2. Resolving or alleviating any other obesity associated diseases that generally do not lead to life threatening consequences
3. A repeat procedure or a revision to the previous procedure due to stretching of a stomach pouch by overeating
4. Any procedure not listed specifically as being covered when criteria are met
5. Liposuction (suction-assisted lipectomy; ultrasonic assisted liposuction)

Hayes, Inc., recommends the National Institute for Health and Clinical Excellence (NICE) guidelines for obesity management published in December 2006. Those physician/facility
guidelines follow:

“Surgical treatment for obesity should be considered for approval only when performed by a multidisciplinary bariatric surgical team able to provide:

- Preoperative assessment to detect any psychological or clinical factors that may affect adherence to postoperative care requirements. The assessment should include a risk-benefit analysis centered on preventing complications of obesity, and specialist assignment for eating disorder(s).
- Information on the various surgery types, including potential weight loss and consequent risks.
- Regular postoperative follow-up by a dietetic specialist and surgeon.
- Manage the patient’s comorbidities.
- Psychological support before and after surgery.
- Information about plastic surgery (such as apronec tomy) where appropriate.
- Access to suitable equipment, including scales, theater tables, Zimmer frames, commodes, hoists, bed frames, pressure-relieving mattresses, and seating suitable for patients undergoing bariatric surgery, and staff trained in how to use them.”

MEDICAL BACKGROUND

Obesity is a significant health concern due to its high prevalence and associated health risks. The Centers for Disease Control and Prevention (CDC) estimate that 34% of adults in the United States, older than the age of 20 are obese. 21 Health problems associated with obesity include hypertension, Type II diabetes, hyperlipidemia, atherosclerosis, heart disease, stroke, diseases of the gallbladder, osteoarthritis, and sleep apnea. Certain cancers are more prevalent in obese individuals.

Obesity and overweight are defined clinically using the body mass index (BMI). The National Heart, Lung and Blood Institute (NHLBI) classify the ranges of BMI in adults as follows (NHLBI, 1998):

• <18.5 kg/m²: Underweight
• 18.5 to 24.9 kg/m²: Normal
• 25-29.9 kg/m²: Overweight
• 30-34.9 kg/m²: Obesity Class I
• 35-39.9 kg/m²: Obesity Class II
• > 40 kg/m²: Extreme Obesity Class III

First-line treatments for obesity include dietary therapy, physical activity, and behavior modification. Pharmacotherapy has provided weight loss of only about 3-10% of a patient’s total body weight and has been associated with undesirable adverse events.

Sjostrom, et al. in a prospective controlled study showed that bariatric surgery appears to be a viable option for the treatment of severe obesity and resulted in long term weight loss, improved lifestyle and improvement in risk factors that were elevated at baseline.22
Patients should have a clear understanding of expected benefits, risks, and long term consequences of surgical treatment as they require appropriate lifelong follow-up with nutritional counseling and biochemical surveillance. It is recommended that all bariatric surgery candidates be evaluated by a licensed mental health care provider experienced in the treatment of severely obese patients and working with a multidisciplinary team. Psychological problems such as depression and personality disorder are associated with less successful obesity surgery outcomes.23

Patient follow-up plays a significant role in the amount of weight loss after bariatric surgery and patient motivation and surgeon commitment for long term follow-up is critical for successful weight loss after bariatric surgery.24

“According to two new studies published in the New England Journal of Medicine, obese patients with diabetes had better glycemic control following bariatric surgery plus intensive medical management than a control group who received intensive medical management alone.” However, because one study was very small and the other had only a limited follow-up period, longer and larger studies are needed to determine whether bariatric surgery can “cure” diabetes. As expected, weight loss was five-fold greater in patients who received bariatric surgery and they required significantly fewer hypoglycemic medications compared to the medical therapy group.25

EndoGastric Solutions Inc., a self-proclaimed pioneer in natural orifice surgery (NOS) developed a revision procedure for patients who have regained weight due to stretching the stomach pouch or outlet by overeating following Roux-en-Y gastric bypass surgery. The StomaphyX revision procedure is performed through the mouth, called the transoral route. Utilizing StomaphyX the surgeon can reduce the stomach pouch and stomach outlet to the original gastric bypass size without making an incision.26 However, the available, appropriate, clinical studies are not sufficient to conduct an assessment of the safety and/or efficacy of either the StomaphyX or the EsophyX System.27 The American Society for Metabolic & Bariatric Surgery (ASBMS) considers Natural Orifice Transluminal Endoscopic Surgery (NOTES) to be an “emerging minimally invasive procedure still in clinical trials”. Both StomaphyX and EsophyX are in the NOTES category and therefore are experimental and/or investigational.28

The silicon intragastric balloon (IGB) has been developed as a temporary aid for obese people who have had unsatisfactory results in their treatment for obesity, and in super obese patients who often have a high risk for surgery. The balloon, placed endoscopically, is designed to float freely inside the stomach to reduce the volume of the stomach and leading to a premature feeling of satiety. Compared with conventional management, IGB has not shown convincing evidence of a greater weight loss. On the other hand, there are complications related to IGB such gastric erosion, reflux, and obstruction.29 Currently, the available evidence in the published, peer-reviewed scientific literature is insufficient to establish the safety and efficacy of this procedure.30

The results and complications of 715 laparoscopic adjustable silicone gastric band (LASGB) patients concluded that LASGB is safe and has a lower complication rate than any other bariatric procedure, and is effective for weight-reducing purposes. The authors note that patient selection must be carefully performed since the procedure itself is only part of the treatment. Patient cooperation, including major changes in life-style and eating habits will be required for success. Professional help may be required following surgery to help the patient deal with problems such as frequent changes to medications and dietary supplements and the rapid changes in body image.31

Vertical banded gastroplasty (VBG) is a well-established bariatric procedure with documented long-term weight control that prior to 1995 was done as an open surgery. In 1995, Morino, et
al, developed a laparoscopic (closed) technique for VBG (LVBG). Their report on 250 consecutive patients showed LVBG was safe and effective in morbidly obese patients, providing good weight loss with a low morbidity rate, no mortality, and minimum discomfort. In super obese patients, however, weight loss results were disappointing and a more complex procedure should be considered. The authors prefer the LVBG to the VBG because of reduced mortality, morbidity, postoperative pain, and length of hospital stay.\(^{32}\)

The laparoscopic sleeve gastrectomy (LSG) approach to weight loss has two main purposes. First, shrinking the stomach reduces the physical capacity of food that can be consumed without interfering with the stomach’s absorption of nutrients, which is a side effect often associated with other weight loss surgeries. LSG is also believed to undermine the stimulation of hunger through hormone modulation. Ghrelin is secreted by the cells lining the fundus of the stomach, and the removal of 75%-85% of which is suspected to result in lower levels of ghrelin production.\(^{33}\) Also, LSG is being described as the method of choice for super obesity.\(^{34}\)\(^{35}\)\(^{36}\)

For these reasons, LSG is considered innovative as compared to other weight loss surgeries. Further, it has several documented advantages including technical efficiency, lack of an intestinal anastomosis, retention of normal intestinal absorption, does not require foreign body implantation, no association with internal hernias, prevents dumping syndrome, and a preservation of the gastrointestinal tract for endoscopic studies. The disadvantages of LSG include the documented complications of risk of staple lining leaks (1.17%) and post-operative hemorrhage (3.57%). LSG is irreversible.\(^{37}\)

In 1990, the Department of Surgery at Hackensack University Medical Center adapted the gastric bypass to VBG by connecting the Roux-en-Y (RGB) limb to the VBG pouch making VBG-RGB the primary procedure for surgical management of obesity. When 652 consecutive patients who underwent this procedure between November 1994 and April 2000 were analyzed, the authors concluded that VBG-RGB is effective in producing superior weight loss in morbidly and super-obese patients, has a low mortality and morbidity rate, and they recommend the procedure without reservations.\(^{38}\)

In a retrospective comparative study of consecutive super-obese patients, 102 patients underwent laparoscopic Roux-en-Y gastric bypass procedure while 79 patients had laparoscopic adjustable gastric banding. Early complications and weight loss outcomes were comparable between the two groups in the short term. However, weight loss and excess weight loss percent at 6 and 12 months of follow-up was significantly higher in patients who underwent Roux-en-Y surgery than gastric banding.\(^{39}\)

The biliopancreatic diversion - duodenal switch (BPD-DS) procedure is sometimes done laparoscopically. The BPD-DS produces weight loss by reducing the absorption of nutrients from the small amounts of food eaten by removing about two-thirds of the stomach, and shortening the small intestine. BPD-DS has a higher complication rate than other obesity surgeries and is usually reserved for extremely obese patients.\(^{40}\)

Weight loss surgery is a new and rapidly developing area of medicine. Surgeons and other medical researchers are constantly working to improve the performance of current procedures and to develop new ones. Because of this there is much controversy over the most effective technique.

Adams, et al. reported in *The Journal of the American Medical Association* on a prospective study of 1156 severely obese (BMI >= 35) participants aged 18 to 72 years. Patients were divided into three control groups, control group 1 consisted of 418 who sought and received Roux-en-Y gastric bypass (RYBG) surgery, control group 2 was made up of 417 patients who sought but did not have the RYBG surgery, and 321 patients who were randomly selected from
a population sample not seeking weight loss surgery were in control group 3. Six years following surgery, weight loss maintenance was superior and diabetic remission rates were 62% in control group 1. Findings from this study are important given the rapid increase in total numbers of bariatric surgeries performed in the United States and world-wide and taking into consideration the projected 31 million patients in the US individuals meeting criteria for bariatric surgeries.  

Medical therapy fails to achieve satisfactory long-term weight control for many morbidly obese patients. The National Institute of Health consensus conferences have affirmed bariatric surgery as effective therapy for patients with severe obesity.  

In a study to compare surgical outcomes of laparoscopic versus open gastric bypass, Nguyen, et al., states that laparoscopic gastric bypass has the potential to become the procedure of choice for a certain group of morbidly obese patients. The authors caution that technical experience in laparoscopic suturing and stapling is necessary for this advanced laparoscopic procedure. 

Several peer-reviewed studies found that diabetic individuals who obtain a moderate weight loss can reduce their risk of death. This was documented in a study by Brown, et al. that found that “Beneficial effects of weight loss have been demonstrated in studies focusing on prevention, treatment and prognosis of diabetes in obese individuals.”  

A 1995 published study found that “Intentional moderate weight loss (<10 kg) has been shown to reduce (-44%) the risk of death from comorbid diabetes in overweight women. Furthermore, each decrease of 1 kg has been estimated to increase life-expectancy by 3–4 months in obese patients with Type 2 diabetes”.  

Scheen, states “Bariatric surgery is probably the only approach able to markedly reduce and sometimes completely correct severe weight excess in the long term. Successful gastroplasty not only fully reverses the abnormalities of insulin secretion, clearance and action on glucose metabolism present in severely obese non-diabetic patients, but also reduces associated cardiovascular risk factors. Most importantly, gastric reduction surgery allows significant improvement of glycaemic control and alleviation (and even interruption) of antidiabetic therapy in most obese patients with Type 2 diabetes, as well as correction of dyslipidaemia and arterial hypertension. Thus, bariatric surgery may be helpful in well-selected severely obese diabetic patients, provided that it is performed by a skilled multidisciplinary team.”  

While there is compelling data in the peer reviewed medical literature, randomized controlled studies, such as the Swedish Obesity Study (SOS) and the National Institutes of Health-supported Study of Health Outcomes of Weight Loss, which are in progress as of this writing, are required to quantify the long-term benefits of bariatric surgery for obese diabetic patients.  

In a very large meta-analysis and systematic review of 136 studies that included 22,094 patients who had undergone bariatric surgery diabetes was completely resolved in 76.8% of patients and resolved or improved in 86% of the patients. Hyperlipidemia was improved in 70% of patients and hypertension was resolved or improved in 78.5%. Obstructive sleep apnea was resolved or improved in 83.6% of the patients. The authors, Buchwald, et al., reported effective weight loss and a substantial improvement of comorbidities as a result of bariatric surgery. Although this report offers impressive improvements in obesity and comorbidities, there was no mention of long-term follow-up. Comparing the results of 136 separate studies would require these authors to assume each of studies was done well and had no errors.  

The Swedish Obese Studies (SOS) reported that obese patients who received surgical treatment for their obesity showed they had significant weight loss and reductions in risk factors for cardiovascular disease such as diabetes, hypertriglyceridemia, and hyperuricemia at both
the two and ten year follow-ups. However, the Hayes Alert report on the SOS notes that it remains to be proven whether these improvements result in prolonged survival.\footnote{47}

Efficacy and safety of bariatric surgery for morbidly obese patients under the age of 18 has not been adequately proven. There is some very limited but positive evidence of the value of bariatric surgery in adolescents, but no long-term reliable studies exist to back up the claim of positive results. Studies are needed on the effects of bariatric surgery on quality of life (QOL), differences in morbidity and mortality with and without surgical procedures, nutritional deficiencies, and impairment of physical maturation.\footnote{48}

### REGULATORY INFORMATION

The Centers for Medicare & Medicaid Services (CMS) announced on February 21, 2006, that “methods of bariatric surgery including laparoscopic and open gastric bypass, laparoscopic adjustable banding, open and laparoscopic biliopancreatic diversion and the duodenal switch” may be covered for select patients.\footnote{49}

Kentucky – No legislative mandates for coverage of treatment of morbid obesity were found.

Tennessee – No legislative mandates for coverage of treatment of morbid obesity were found.

Indiana – The Indiana Senate Enrolled Act No. 360, effective July 1, 2005, requires health care plans to offer coverage for nonexperimental, surgical treatment by a health care provider, of morbid obesity that has persisted for at least five years and for which nonsurgical treatment, supervised by a physician for at least 18 months has been unsuccessful, for insured persons who meet the following criteria:

- Morbid obesity (defined as a BMI of 35 or more with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes), or
- Morbid obesity (defined as a BMI of 40 or more without comorbidity
- No coverage is provided for an insured who is less than 21 years of age unless two physicians licensed under IC 25-22.5 determine that the surgery is necessary to:
  - Save the life of the insured, or
  - Restore the insured’s ability to maintain a major life activity (as defined in IC 4-23-29-6)
- Each physician must document in the insured’s medical records the reason for his/her determination.\footnote{50}

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. In addition, coverage for Medicare Advantage members may differ. This is a result of applicable coverage statements by the Center for Medicare and Medicaid Services (CMS). The National Coverage Determinations, Local Coverage Determinations, and Local Medical Review Policies may be found at the CMS website, \url{http://www.cms.gov}. Please note that for all plans, the member’s health plan benefits that are in effect on the rendered date of service must be used in coverage determinations.
## COVERAGE DETAIL

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.

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
<th>Coverage Information</th>
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<tbody>
<tr>
<td>43631</td>
<td>Gastrectomy, partial, distal; with gastroduodenostomy</td>
<td>Not medically necessary and/or experimental/investigational</td>
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<tr>
<td>43632</td>
<td>Gastrectomy, partial distal; with gastrojejunostomy</td>
<td>Not medically necessary and/or experimental/investigational</td>
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<tr>
<td>43633</td>
<td>Gastrectomy, partial, distal; with Roux-en-Y reconstruction</td>
<td>Not medically necessary and/or experimental/investigational</td>
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<td>43634</td>
<td>Gastrectomy, partial, distal; with formation of intestinal pouch</td>
<td>Not medically necessary and/or experimental/investigational if used to report laparoscopic</td>
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<tr>
<td>43644</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roxb limb 150 cm or less)</td>
<td>Not medically necessary and/or experimental/investigational</td>
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<td>43645</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption</td>
<td>If not excluded by COC may be medically necessary when all criteria are met</td>
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<tr>
<td>43659</td>
<td>Unlisted laparoscopy procedure, stomach</td>
<td>Not medically necessary and/or experimental/investigational if used to report laparoscopic gastric plication (laparoscopic greater curvature plication) with or without gastric banding</td>
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<td>43770</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components)</td>
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<td>43771</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric band component only</td>
<td>If not excluded by COC may be medically necessary when all criteria are met</td>
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<td>CPT Codes</td>
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<td>43772</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band component only</td>
<td>If not excluded by COC may be medically necessary when all criteria are met</td>
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<tr>
<td>43773</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric band component only</td>
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<tr>
<td>43774</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band and subcutaneous port components</td>
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<td>43775</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)</td>
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<tr>
<td>43773</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band component only</td>
<td>If not excluded by COC may be medically necessary when all criteria are met</td>
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<td>43842</td>
<td>Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty</td>
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<td>43843</td>
<td>Gastric restrictive procedure, without gastric bypass, for morbid obesity with construction of gastric tube (e.g. Janeway procedure)</td>
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<td>43845</td>
<td>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)</td>
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<td>43846</td>
<td>Gastric restrictive procedure, with gastric bypass, for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy</td>
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<td>43847</td>
<td>Gastric restrictive procedure, with gastric bypass, for morbid obesity; with small bowel reconstruction to limit absorption</td>
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<td>43848</td>
<td>Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric band (separate procedure)</td>
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<tr>
<td>43848</td>
<td>Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)</td>
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<td>43850</td>
<td>Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy</td>
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<td>Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy</td>
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<td>Gastric restrictive procedure, open; revision of subcutaneous port component only</td>
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<td>43887</td>
<td>Gastric restrictive procedure, open; removal of</td>
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subcutaneous port component only be medically necessary when all criteria are met

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<td>S2083</td>
<td>Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline</td>
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<td>S9449</td>
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<td>Not medically necessary and/or experimental/investigational</td>
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<td>S9451</td>
<td>Exercise classes, nonphysician provider, per session</td>
<td>Not medically necessary and/or experimental/investigational</td>
</tr>
<tr>
<td>S9452</td>
<td>Nutrition classes, nonphysician provider, per session</td>
<td>Not medically necessary and/or experimental/investigational</td>
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<table>
<thead>
<tr>
<th>ICD.9® Diagnosis Codes</th>
<th>Description</th>
<th>Coverage Information</th>
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<tbody>
<tr>
<td>278.00 – 278.01</td>
<td>Obesity unspecified, morbid obesity</td>
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<tr>
<td>278.03</td>
<td>Obesity hypoventilation syndrome (Pickwickian syndrome)</td>
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<tr>
<td>V45.86</td>
<td>Bariatric surgery status</td>
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<td>V53.51</td>
<td>Fitting and adjustment of gastric lap band</td>
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<tr>
<td>V77.8</td>
<td>Special screening for endocrine, nutritional, metabolic, and immunity disorders; Obesity</td>
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<td>V85.35 – V85.39</td>
<td>Body Mass Index 35.0 – 39.9, adult</td>
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<tr>
<td>V85.41 – V85.45</td>
<td>Body Mass Index 40 and over, adult</td>
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<tr>
<td>V85.51 – V85.54</td>
<td>Body Mass Index, pediatric (special consideration)</td>
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<td>ICD.9® Procedure Codes</td>
<td>Description</td>
<td>Coverage Information</td>
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<tr>
<td>------------------------</td>
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<td>----------------------</td>
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<tr>
<td>43.6</td>
<td>Partial gastrectomy with anastomosis to deduodenum</td>
<td>Not medically necessary and/or experimental/investigational</td>
</tr>
<tr>
<td>43.7</td>
<td>Partial gastrectomy with anastomosis to jejunum</td>
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<td>43.82</td>
<td>Laparoscopic vertical (sleeve) gastrectomy</td>
<td>Not medically necessary and/or experimental/investigational</td>
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<tr>
<td>43.89</td>
<td>Open and other partial gastrectomy</td>
<td>If not excluded by COC may be medically necessary when all criteria are met</td>
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<tr>
<td>44.31</td>
<td>High gastric bypass</td>
<td>If not excluded by COC may be medically necessary when all criteria are met</td>
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<td>44.38</td>
<td>Laparoscopic gastroenterostomy</td>
<td>If not excluded by COC may be medically necessary when all criteria are met</td>
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<tr>
<td>44.39</td>
<td>Other gastroenterostomy without gastrectomy</td>
<td>If not excluded by COC may be medically necessary when all criteria are met</td>
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<tr>
<td>44.5</td>
<td>Revision of gastric anastomosis</td>
<td>If not excluded by COC may be medically necessary when all criteria are met</td>
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<tr>
<td>44.68</td>
<td>Laparoscopic gastroplasty</td>
<td>If not excluded by COC may be medically necessary when all criteria are met</td>
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<tr>
<td>44.93</td>
<td>Insertion of gastric bubble (balloon)</td>
<td>Not medically necessary and/or experimental/investigational</td>
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<tr>
<td>44.94</td>
<td>Removal of gastric bubble (balloon)</td>
<td>Not medically necessary and/or experimental/investigational</td>
</tr>
<tr>
<td>44.95</td>
<td>Laparoscopic gastric restrictive procedure</td>
<td>If not excluded by COC may be medically necessary when all criteria are met</td>
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<td>44.96</td>
<td>Laparoscopic revision of gastric restrictive procedure</td>
<td>Not medically necessary and/or experimental/investigational</td>
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<td>Code</td>
<td>Description</td>
<td>Medical Necessity</td>
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<td>----------------------------------------------------------</td>
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<td>44.97</td>
<td>Laparoscopic removal of gastric restrictive device(s)</td>
<td>If not excluded by COC may be medically necessary when all criteria are met</td>
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<tr>
<td>44.98</td>
<td>(Laparoscopic) adjustment of size of adjustable gastric restrictive device</td>
<td>If not excluded by COC may be medically necessary when all criteria are met</td>
</tr>
</tbody>
</table>

### Height-for-Weight Chart

![Height-for-Weight Chart](chart.png)


* Without shoes
* Without clothes. The higher weights apply to people with more muscle and bone, such as many men.
### Body Mass Index Chart

**Calculate your Body Mass Index**

<table>
<thead>
<tr>
<th>Height (in)</th>
<th>Weight (lbs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4'10</td>
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</tr>
<tr>
<td>4'11</td>
<td></td>
</tr>
<tr>
<td>5'0</td>
<td></td>
</tr>
<tr>
<td>5'1</td>
<td></td>
</tr>
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<td>5'2</td>
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<td>5'3</td>
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<td>5'4</td>
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<td>5'6</td>
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<td>6'1</td>
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<td>6'2</td>
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<td>6'3</td>
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<tr>
<td>6'4</td>
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</tr>
<tr>
<td><strong>BMI</strong></td>
<td></td>
</tr>
<tr>
<td><strong>58</strong></td>
<td>21 20 19 18 17 16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1</td>
</tr>
</tbody>
</table>
RESEARCH


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Bariatric Surgery for Morbid Obesity
07/22/16; 07/11/13; 03/09/11; 11/26/10; 02/18/09; 09/24/07; 04/07/06; 08/26/05; 08/05/04


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50 Indiana Government web site. Enrolled Act, Senate Bill 0360. Available at:


SEARCH TERMS

Band
Bariatric Surgery
Body Mass Index (BMI)
Diabetes
Diet
Gastrectomy
Gastric bypass
Gastroplasty
Gastric banding
Gastric pouch
Laparoscopic
Lapband
Malabsorptive
Obese
Obesity
Restrictive
Weight loss