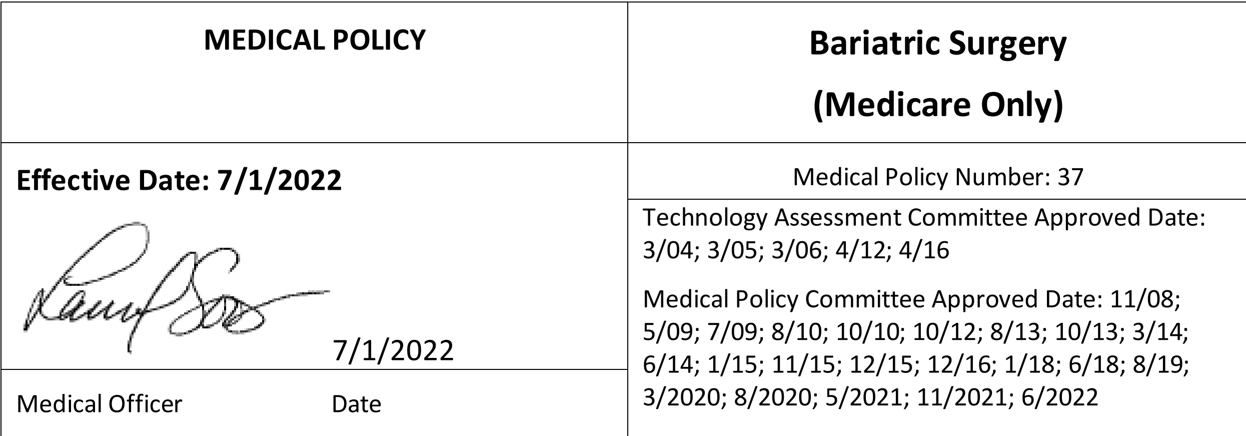

MEDICAL POLICY	Bariatric Surgery (Medicare Only)
Effective Date: 7/1/2022 7/1/2022 Medical Officer Date	Medical Policy Number: 37 Technology Assessment Committee Approved Date: 3/04; 3/05; 3/06; 4/12; 4/16 Medical Policy Committee Approved Date: 11/08; 5/09; 7/09; 8/10; 10/10; 10/12; 8/13; 10/13; 3/14; 6/14; 1/15; 11/15; 12/15; 12/16; 1/18; 6/18; 8/19; 3/2020; 8/2020; 5/2021; 11/2021; 6/2022

See Policy CPT CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Bariatric surgical procedures subject to NCD 100.1 • *Roux-en-Y gastric bypass (**RYGBP**)* • *Biliopancreatic Diversion with Duodenal Switch (**BPD/DS**)* • *Gastric Reduction Duodenal Switch (**BPD/GRDS**)* • *Adjustable gastric banding* • *Sleeve Gastrectomy* • *Vertical banded gastroplasty* • *Intestinal bypass surgery* • *Gastric balloon for treatment of obesity.*	General coverage criteria: • National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Morbid Obesity (100.1) **NOTES:** 1. For information, including examples, of Medicare’s requirements for co-morbid conditions and prior medical treatments related to obesity, see the *Local Coverage Article (LCA) for Bariatric Surgery Coverage (A53028).* 2. The following bariatric procedures may be **medically necessary** when NCD criteria are met: A. Roux-en-Y Gastric Bypass (RYGBP) (**open and laparoscopic**)

	B. Biliopancreatic Diversion with Duodenal Switch (BPD/DS) (**open and laparoscopic**) C. Gastric Reduction Duodenal Switch (BPD/GRDS) (**open and laparoscopic**) D. **Laparoscopic** Adjustable Gastric Banding (AGB) E. **Laparoscopic** Sleeve Gastrectomy 3. According to the above NCD, the following procedures are considered **not medically necessary** for any indication. A. **Open** adjustable gastric banding; B. **Open** sleeve gastrectomy; C. **Open and laparoscopic** vertical banded gastroplasty; D. Intestinal bypass surgery; and, E. Gastric balloon for treatment of obesity.
Treatment of complications resulting from a prior bariatric surgery (e.g., bleeding, fistula, infection, leak, obstruction, etc.)	*Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare* **NOTE:** I. Treatment of complications resulting from a prior bariatric surgery may be **medically necessary** when conditions of the above Medicare manual reference are met. This includes possible coverage for treatment of complications related to bariatric surgeries which did **not** meet coverage criteria. II. Removal of vagus nerve blocking neurostimulators ors generators **without** replacement with a new device (0314T, 0315T) may be **medically necessary**.
Repeat or Revision Bariatric Surgery Procedures	I. Repeat or revision bariatric surgery procedures may be considered **medically necessary** for Medicare when criteria from the Commercial *Bariatric Surgery (All Lines of Business Except Medicare)* policy are met. II. Repeat or revision bariatric surgery procedures are considered **not medically necessary** for Medicare when criteria from the Commercial *Bariatric Surgery (All Lines of Business Except Medicare)* policy are **not** met. *Services deemed "investigational" are*

	<u>*considered not medically necessary for Medicare Plan members.*</u> See *Policy Guidelines.*
All other bariatric surgery procedures not otherwise addressed	I. <u>*Services deemed "investigational" are considered not medically necessary for Medicare Plan members.*</u> Therefore, the following services are considered **not medically necessary** for Medicare, based on the commercial *Bariatric Surgery (All Lines of Business Except Medicare)* policy*:* • Vagus nerve blocking therapy (CPT 0312T, 0313T, 0316T, 0317T) • Transcatheter bariatric embolotherapy See *Policy Guidelines.*

POLICY GUIDELINES

<u>Medicare and Medical Necessity</u>

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.), Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. *(Medicare Managed Care Manual, Ch. 4, §90.5)*

Following an evidence-based assessment of current peer-reviewed medical literature, the Company may consider certain medical services or technologies to be "investigational." The term "investigational" is not limited to devices or technologies which have not received the appropriate governmental regulatory approval (e.g., U.S. Food and Drug Administration [FDA]), but rather may also mean the procedure, device, or technology does not meet all of the Company's technology assessment criteria, as detailed within the Company policy for *Definition: Experimental/Investigational* (MP5).

For Medicare, only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. Thus, services which lack scientific evidence regarding safety and efficacy because they are investigational are "not medically reasonable or necessary" for Medicare Plan members. *(Medicare Claims Processing Manual, Ch. 23, §30 A)*

BILLING GUIDELINES

Only the codes listed on this policy may be used for reporting bariatric procedures. Codes 43631-43634 are specific to gastrectomy and should not be used to report bariatric procedures.

Code 43843 should not be used when there is a procedure-specific bariatric surgery code.

Finally, the *National Physician Fee Schedule Relative Value File (NPFSRVF)*, which is published by Medicare[1], indicates CPT code 43842 has been assigned a Status Indicator of "N," which is defined as "Non-covered Services." This is a statutorily excluded service based on the above NCD.

CPT CODES

Note: According to Medicare, "The presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." Therefore, the issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or covered by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)*

Medicare Only	
Prior Authorization Required	
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
Roux-en-Y Gastric Bypass	
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
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
Adjustable Gastric Banding (e.g., LAP-BAND®)	
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
Sleeve Gastrectomy	
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)
Biliopancreatic Bypass with Duodenal Switch	

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)
Removal/Revision of Bariatric Surgery	
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
~~43850~~	TERMED 12/31/2021 ~~Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy~~
~~43855~~	TERMED 12/31/2021 ~~Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; with vagotomy~~
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy
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
Not Covered	
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
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
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty

Unlisted Codes All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then **prior-authorization is required.**	
43659	Unlisted laparoscopy procedure, stomach
43999	Unlisted procedure, stomach

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days' notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

REFERENCES

1. Medicare Physician Fee Schedule (PFS) Relative Value Files; Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files