Bariatric Surgery

I. Policy

University Health Alliance (UHA) will reimburse for bariatric surgery when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

A. Surgery for morbid obesity will be covered for members when the following criteria are met:

1. Presurgery counseling and medical clearance meet nationally accepted guidelines.
2. The patient is morbidly obese, defined as either of the following:
   a. Persistent and uncontrollable weight gain that constitutes a present or potential threat to life,
      i. Weight that is at least 100 pounds over or twice the ideal weight as described in the Metropolitan Life tables; or
      ii. A BMI greater than 40 kg/m²; or
   b. BMI of between 35 and 40 kg/m² with one of the following high-risk comorbidities:
      i. Severe sleep apnea (defined as repeated hypoxia with oxygen saturation less than 80% on sleep study; or documented pulmonary hypertension on echocardiogram or right heart catheterization; or sleep apnea induced right heart failure requiring hospitalization).
      ii. Pickwickian syndrome
      iii. Obesity-related cardiomyopathy
      iv. Diabetes mellitus with evaluation and recommendation for surgery by a multi-disciplinary team with expertise in weight, metabolic, and diabetic management and which is part of a comprehensive weight management program associated with the facility that will perform the operation.
   c. BMI of between 30 and 34.9 kg/m² with type II diabetes mellitus with evaluation and recommendation for roux-en-Y gastric bypass surgery by a multi-disciplinary team with expertise in weight, metabolic, and diabetic management and which is part of a comprehensive weight management program associated with the facility where the surgery will be performed.
      i. For this category of patient, only Roux-en-Y gastric bypass is covered as the evidence has shown compelling benefit specifically with this particular operation, and not the other alternatives
   d. Morbid obesity in adolescents must meet the same weight-based criteria used for adults but greater consideration will be given to psychosocial and informed consent issues. All devices must be used in accordance with FDA-approved indications.

3. The surgery is intended to achieve one of two results:
   a. Alteration of the mechanics of food absorption; or
b. Alteration in the volume of food ingested.

4. There is documentation that the patient's efforts to lose weight have not been successful.

B. Revisions, replacements, and re-dos of bariatric procedures will be covered if the patient met policy criteria at the time of the initial procedure, and there is documentation of a medically significant complication or failure.

C. Bariatric surgery is covered only if the patient meets the criteria outlined above and when:

1. The bariatric facility is located in the state of Hawaii and has a comprehensive weight management program; or if out of state, the program is:

   a. Certified by the American College of Surgeons as a Level One Bariatric Surgery Center, or by the American Society of Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence, or certified by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), and

   b. Has arranged an agreement for continuity of care in the state where the member primarily resides, and

   c. Prior authorization has been obtained for out of state treatment.

D. **NOTE:**

   *This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.*

   Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. **UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.**

   UHA understands that opinions about and approaches to clinical problems may vary. **Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.**

### III. Limitations/Exclusions

A. When requesting prior authorization, the physician should submit specific documentation about the member’s comorbidities, complex problems, age considerations, etc., if requesting that a lap band procedure be performed as an inpatient.

B. Polysomnography performed as part of the routine evaluation of patients prior to bariatric surgery is not covered as it is not known to be effective in improving health outcomes. **AND**

C. Esophagogastroduodenoscopy performed as part of the routine evaluation of patients prior to bariatric surgery is not covered as it is not known to be effective in improving health outcomes.

### IV. Administrative Guidelines

A. Prior authorization is required.

To request prior authorization, please go to UHA’s website: [https://uhahealth.com/page/prior-authorization-forms](https://uhahealth.com/page/prior-authorization-forms) to submit via online.
### CPT Codes

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43644</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenteroscopy (roux limb 150 cm or less)</td>
</tr>
<tr>
<td>43645</td>
<td>with gastric bypass and small intestine reconstruction to limit absorption</td>
</tr>
<tr>
<td>43770</td>
<td>Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components)</td>
</tr>
<tr>
<td>43771</td>
<td>revision of adjustable gastric band component only</td>
</tr>
<tr>
<td>43772</td>
<td>removal of adjustable gastric band component only</td>
</tr>
<tr>
<td>43773</td>
<td>removal and replacement of adjustable gastric band component only</td>
</tr>
<tr>
<td>43774</td>
<td>removal of adjustable gastric band and subcutaneous port components</td>
</tr>
<tr>
<td>43842</td>
<td>Gastric restrictive procedure, without gastric bypass for morbid obesity; vertical-banded gastroplasty</td>
</tr>
<tr>
<td>43843</td>
<td>other than vertical-banded gastroplasty</td>
</tr>
<tr>
<td>43845</td>
<td>Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenileostomy and ileoleostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)</td>
</tr>
<tr>
<td>43846</td>
<td>Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy</td>
</tr>
<tr>
<td>43847</td>
<td>with small intestine reconstruction to limit absorption</td>
</tr>
<tr>
<td>43848</td>
<td>Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric band (separate procedure)</td>
</tr>
<tr>
<td>43886</td>
<td>Gastric restrictive procedure, open; removal of subcutaneous port component only</td>
</tr>
<tr>
<td>43887</td>
<td>Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only</td>
</tr>
<tr>
<td>43888</td>
<td>Percutaneous placement of IVC filter, radiological supervision and interpretation</td>
</tr>
<tr>
<td>43999</td>
<td>Unlisted procedure, stomach</td>
</tr>
</tbody>
</table>

### V. Policy History

- **Policy Number:** M.SUR.08.120301
- **Current Effective Date:** 09/01/2016
- **Original Document Effective Date:** 03/01/2012
- **Previous Revision Dates:** 09/01/2016
- **PAP Approved:** 03/01/2012