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Northwest Region Utilization Review

UR 10 Bariatric Surgery
Medical Necessity Criteria

Department: Surgery	Number: UR 10.A
Section: KPNW Region	Effective: 3/2000
Applies to: Bariatric Surgery	Last Reviewed: 3/23
Review Responsibility:	Last Revised: 5/24, 8/24, 2/25, 8/19/25
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POLICY AND CRITERIA

Coverage Guidance: Bariatric surgery may be excluded from coverage. Check CM for exclusions or limitations.

Source	Policy
For Medicare Members	
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	NCD 100.1 "Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity"
Local Coverage Determinations (LCD)	None
Local Coverage Article	A53028 "Billing and Coding: Bariatric Surgery Coverage"
Kaiser Permanente Medical Policy for Medicare Members	UR 10 does not apply. For Medicare lines of business, apply the criteria in the NCD with support from the Billing and Coding Article (A53028).
For Medicaid Members	
OR Medicaid	UR 10 does not apply. Check Linefinder
WA Medicaid	UR 10 does not apply. Check WA Healthcare Authority guidelines (determinations made by Molina)
For Commercial & Self-Funded Members	
OR Commercial	UR 10 applies
WA Commercial	UR 10 applies
Self-Funded Plans	UR 10 applies

MEDICAL NECESSITY CRITERIA AND OTHER REQUIREMENTS FOR THE BARIATRIC SURGERY PREPARATION PROGRAM (NOTE: admission into the Program, also known as the Severe Obesity Program, is required prior to consideration of bariatric surgery)

CRITERIA

Patients will be eligible to participate in the preparation process and may be a candidate for bariatric surgery if:

1. Body Mass Index (BMI) is >35 kg/m2

   AND

2. Be ≥18 years old and general health adequate to tolerate surgery;

AND,

3. Members with a history of tobacco products* use must have a documented "quit" date ≥6 weeks prior to referral for consultation.

   *tobacco products: cigarettes, cigars, pipe tobacco, e-cigarettes, smokeless tobacco (chewing tobacco and snuff).

NOTE: Currently, the bariatric surgical procedures offered at KPNW are limited to laparoscopic or robotic Roux-en-Y Gastric Bypass (RNYGB) and laparoscopic or robotic sleeve gastrectomy, and laparoscopic or robotic single anastomosis duodenal-ileal bypass. The type of surgical procedure performed is up to the clinical discretion of the surgeon.

Roux-en-Y Gastric Bypass (RYGBP) is a procedure that restricts the size of the stomach by stapling shut 90% of the lower stomach and bypassing the nearby intestine.

Sleeve Gastrectomy is an irreversible surgical removal of a large portion of the stomach along the greater curvature in which the stomach is reduced to about 25% of its original size.

Single anastomosis duodenal-ileal bypass is a procedure in which the stomach is disconnected from the first portion of the small intestine and connected to the lower portion of the small intestine, effectively bypassing most of the small intestine.

OTHER REQUIREMENTS

After the bariatric surgery referral, but prior to bariatric surgery, the member must complete ***all*** program requirements. Surgical clearance must be received.

OTHER CONSIDERATIONS

1. Surgical risk determinations: Individuals with BMI >60 and/or age >60 years are at higher surgical risk. Decisions regarding the appropriateness of surgery will be made individually based on rehabilitation potential and the physician and surgeon's judgment regarding surgical risk and likelihood of benefit.

2. Revisional bariatric surgery: Patients who have previously had bariatric surgery requesting re-operation for weight loss or severe reflux will be managed individually as part of a shared decision-making process with their consulting surgeon.

3. Patients will need to have their current behaviors carefully assessed and surgery will not be recommended unless current behaviors are conducive to post-operative success.

4. Patients requesting repeat bariatric procedures need to have their prior operative records obtained to define post-surgical anatomy. If this is not possible, an upper GI x-ray may be useful. If metabolic, renal, or hepatic complications are present from prior jejunoileal bypass, general surgery referral is recommended regardless of the BMI status to discuss revision of this operation unless clinical cirrhosis or other conditions are present that would increase operative risk to unacceptable levels.

CONTRAINDICATIONS TO BE DETERMINED PRE-OPERATIVELY BY THE SURGEON

1. Current pregnancy or desire for pregnancy in the next 18 months
2. Alcohol or substance abuse within the last year
3. Nicotine use, including *tobacco products and nicotine replacement therapy (NRT) **products within 6 weeks prior to surgery

   *tobacco products: cigarettes, cigars, pipe tobacco, e-cigarettes, smokeless tobacco (chewing tobacco and snuff).

   **NRT products: nicotine gum, lozenges, sublingual tablets, transdermal patch, nasal spray, inhaler.
4. Uncontrolled major psychiatric disorder. If you suspect the presence of uncontrolled depression, suicidal ideation, paranoid ideation, psychotic disorder, multiple personality disorder or active/untreated eating disorder i.e. bulimia, a NW Permanente Psychiatrist must be consulted pre-referral to ascertain control.
5. Endogenous reasons for obesity i.e. Cushing's disease
6. Clinical cirrhosis or advanced liver disease is a contraindication to bariatric surgery due to excessive operative mortality. Patients with hepatitis C or chronic active hepatitis B, prior jejunoileal bypass, or chronically abnormal liver tests of any cause should be evaluated with further testing including transaminase levels, tests of hepatic synthetic function (albumin and PT/INR), CBC, and abdominal ultrasound with doppler. If significant abnormalities are found (i.e., ascites, hepatofugal blood flow, splenomegaly, thrombocytopenia, albumin < 3, coagulopathy despite vitamin K replacement, referral to gastroenterology is recommended for further evaluation prior to consideration of bariatric surgery. Although fatty infiltration of the liver and NASH (non-alcoholic steatohepatitis) are the most common causes of abnormal transaminase levels in severely obese patients, persistently abnormal liver tests should have serologic evaluation for chronic viral hepatitis as well as other causes of transaminase elevation.
7. Other conditions that the primary care provider, bariatric surgeon, KPNW consultant, or Severe Obesity Team members feel would raise the risk of surgery to unacceptable levels.

RATIONALE

EVIDENCE BASIS

The KP National Guideline Program clinical practice guideline recommendations include a summary of the evidence relevant to selecting patients for bariatric surgery. Brief excerpts from that evidence summary are included here:

"Efficacy:

- Weight loss: In obese adults, bariatric surgery produces greater weight loss and maintenance of lost weight than that produced by usual care, conventional medical treatment, lifestyle intervention, or medically supervised weight loss, and weight loss efficacy varies depending on the type of procedure and initial body weight.
    - Weight loss at 2 to 3 years following a variety of surgical procedures in adults with presurgical BMI ≥30 varies from a mean of 20% to 35% of initial weight and a mean difference from nonsurgical comparators of 14% to 37% depending on procedure. (SOE: High)
    - Mean weight loss at 10 years following a variety of bariatric surgical procedures (predominantly vertical banded gastroplasty) is approximately 16% of initial weight, representing a mean weight regain of 7%. (SOE: Low)

- Comorbidities: In obese adults, bariatric surgery generally results in more favorable impact on obesity-related comorbid conditions than that produced by usual care, conventional medical treatment, lifestyle intervention, or medically supervised weight loss.
    - Glycemic control
        - At 2 to 3 years following a variety of bariatric surgical procedures in adults with BMI ≥30 who achieve a mean weight loss of 20% to 35%, there is a ↓in FPG, insulin and incidence of T2DM and there is a greater likelihood of diabetes remission among those with T2DM at baseline. Remission was defined variously depending on the study. (SOE: high)
        - At 10 years, incidence and prevalence of T2DM are lower in those who have undergone surgery. However, among those in whom T2DM remits after surgery, diabetes may recur over time. (SOE: low)
    - Blood pressure control
        - At 2 to 3 years following a variety of bariatric surgical procedures in adults with BMI ≥30 who achieve mean weight loss of 20% to 35%, blood pressure or use of blood pressure medication is reduced compared with nonsurgical management. Blood pressure tends to increase over time, and at 10 years post-surgery, there is no difference in mean SBP or the incidence of new cases of hypertension in those who underwent bariatric surgery compared to those who did not undergo surgery. (SOE: low)
        - Among obese adults with baseline hypertension, a greater percentage is in remission at 2 to 3 years and 10 years following bariatric surgery compared with nonsurgical management. (SOE: low)
    - Cholesterol and lipid control
        - At 2 to 3 years and 10 years following a variety of bariatric surgical procedures in adults with BMI ≥30 who achieve mean weight loss of 20% to 35%, serum TG levels are lower, HDL-C levels are higher, TC-to-HDL-C ratio is lower, and changes in TC or LDL-C levels are inconsistent compared with nonsurgical management. (SOE: low)
    - Quality of life
        - Most measures of health-related quality of life (HRQOL) are improved at 2 and 10 years following bariatric surgery. (SOE: moderate)
    - Total mortality
        - Total mortality is decreased compared with nonsurgical management at mean follow-up of 11 years after undergoing a variety of bariatric surgical procedures (predominantly vertical banded gastroplasty) in patients with mean BMI >40 who achieve a mean long-term weight loss of 16% (SOE: low)
    - CVD risk
        - There are insufficient data on the efficacy of bariatric surgical procedures for weight loss and maintenance or CVD risk factors 2 or more years post-surgery in patients with a BMI <35.

Complications:

Perioperative (≤30 days) and longer term (>30 days) complications following bariatric surgery vary by procedure and patient-derived risk factors.

- Roux-en-Y Gastric Bypass.
    - When performed by an experienced surgeon, perioperative complications following laparoscopic gastric bypass:
        - Consist of a major adverse outcome in approximately 4% to 5%, including mortality (0.2%), DVT and/or pulmonary embolism (PE) (0.4%), and a requirement

for reoperation (3% to 5%). Rates of any complication, major or minor, range from 2% to 18%. (SOE: moderate)
        - Are less frequent for the laparoscopic approach than for open incision. (SOE: moderate)
        - When performed by an experienced surgeon, perioperative complications following open gastric bypass:
            - Consist of a major adverse outcome in approximately 8%, including mortality (2%), DVT/PE (1%), and reoperation (5%). (SOE: low)
        - When performed by an experienced surgeon, perioperative complications following gastric bypass (laparoscopic or open):
            - Are associated with extremely high BMI, inability to walk 200 feet, history of DVT/PE, and history of obstructive sleep apnea. (SOE: low)
- Laparoscopic Sleeve Gastrectomy
    - There is insufficient evidence to establish the incidence of perioperative and longer-term complications."

The American Society of Metabolic and Bariatric Surgery recommendations[6] include a summary of the evidence relevant to selecting patients for bariatric surgery. Brief excerpts from that evidence summary are included here:

- "Since the NIH published its statement on gastrointestinal surgery for severe obesity in 1991, the understanding of obesity and MBS has significantly grown based on a large body of clinical experience and research.
- Long-term data consistently demonstrate the safety, efficacy, and durability of MBS in the treatment of clinically severe obesity and its co-morbidities, with a resultant decreased mortality compared with nonoperative treatment methods.
- MBS is recommended for individuals with BMI >35 kg/ m2, regardless of presence, absence, or severity of co-morbidities.
- MBS is recommended in patients with T2D and BMI >30 kg/m2.
- MBS should be considered in individuals with BMI of 30–34.9 kg/m2 who do not achieve substantial or durable weight loss or co-morbidity improvement using nonsurgical methods.
- Obesity definitions using BMI thresholds do not apply similarly to all populations.
- Clinical obesity in the Asian population is recognized in individuals with BMI >25 kg/m2
- Access to MBS should not be denied solely based on traditional BMI risk zones.
- There is no upper patient-age limit to MBS. Older individuals who could benefit from MBS should be considered for surgery after careful assessment of co-morbidities and frailty.
- Carefully selected individuals considered higher risk for general surgery may benefit from MBS.
- Children and adolescents with BMI >120% of the 95th percentile and a major co-morbidity, or a BMI >140% of the 95th percentile, should be considered for MBS after evaluation by a multidisciplinary team in a specialty center.
- MBS is an effective treatment of clinically severe obesity in patients who need other specialty surgery, such as joint arthroplasty, abdominal wall hernia repair, or organ transplantation.

- Consultation with a multidisciplinary team can help manage the patient's modifiable risk factors with a goal of reducing risk of perioperative complications and improving outcomes. The ultimate decision for surgical readiness should be determined by the surgeon.
- Severe obesity is a chronic disease requiring long-term management after primary MBS. This may include revisional surgery or other adjuvant therapy to achieve desired treatment effect."

REFERENCES

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2. Maggard MA, Shugarman LR, Suttorp M, et al. Meta-analysis: surgical treatment of obesity. Ann Intern Med 2005;142:547-559
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6. KP National Guideline Committee. (2022) Management of Overweight and Obesity in Adults Clinical Practice Recommendations. Available at: https://cl.kp.org/natl/cmi/programs/weight_mgmt/guideline/index.html
7. 2022 American Society for Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO): Indications for Metabolic and Bariatric Surgery. Dan Eisenberg et al. / Surgery for Obesity and Related Diseases 18 (2022) 1345–1356.