

# Molina Clinical Policy

## Pediatric Bariatric Surgery: Policy No. 091

Last Approval: 8/11/2021

Next Review Due By: August 2022



### DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members.<sup>1</sup> References included were accurate at the time of policy approval and publication.

### OVERVIEW

Surgical treatment of obesity involves reducing the size of the stomach to restrict calorie intake and/or changing the intestinal anatomy to induce malabsorption. The goals of surgical treatment for obesity are to induce significant weight loss and, thereby, reduce the incidence or progression of obesity-related comorbidities, as well as to improve quality of life. The purpose of performing bariatric surgery in pediatric patients is to reduce the lifelong impact of severe obesity. The two most common bariatric surgical procedures are laparoscopic adjustable gastric banding (LAGB), which is a purely restrictive procedure, and Roux-en-Y gastric bypass (RYGB), which is both restrictive and malabsorptive. Alternatives to bariatric surgery include dietary modification, increasing physical activity and exercise, behavioral modification, and pharmacotherapy. Bariatric surgery procedures include:<sup>2-4</sup>

- **Roux-en-Y Gastric Bypass (RYGBP)** achieves weight loss by gastric restriction and malabsorption. Reduction of the stomach to a small gastric pouch (30 cc) results in feelings of satiety following even small meals. The small pouch is connected to a segment of the jejunum, bypassing the duodenum and very proximal small intestine, thereby reducing absorption. RYGBP procedures can be open or laparoscopic.
- **Laparoscopic Adjustable Gastric Banding (LAGB/AGB)** achieves weight loss by gastric restriction only. A band creating a gastric pouch with a capacity of 15-30 cc's encircles the uppermost portion of the stomach. The adjustable band is an inflatable doughnut-shaped balloon, the diameter of which can be adjusted in the clinic by adding or removing saline via a port that is positioned beneath the skin. This allows the size of the gastric outlet to be modified as needed, depending on the rate of weight loss. AGB procedures are generally performed as a laparoscopic procedure.
- **Biliopancreatic Diversion with Duodenal Switch (BPD/DS)** achieves weight loss by gastric restriction and malabsorption. The stomach is partially resected, but the remaining capacity is generous compared to that achieved with RYGBP. Patients eat relatively normal-sized meals and do not need to restrict intake radically, since the most proximal areas of the small intestine (e.g., duodenum and jejunum) are bypassed, and substantial malabsorption occurs. The partial BPD/DS are a variant of the BPD procedure and involves resection of the greater curvature of the stomach, preservation of the pyloric sphincter, and transection of the duodenum above the ampulla of Vater with a duodeno-ileal anastomosis and a lower ileo-ileal anastomosis. BPD/DS procedures can be open or laparoscopic.
- **Vertical Sleeve Gastrectomy (VSG)** is a 70%-80% greater curvature gastrectomy (sleeve resection of the stomach) with continuity of the gastric lesser curve being maintained while simultaneously reducing stomach volume. It may be the first step in a two-stage procedure when performing RYGBP. Sleeve gastrectomy procedures can be open or laparoscopic.
- **Vertical Gastric Banding or Vertical Banded Gastroplasty (VGB or VBG)** achieves weight loss by gastric restriction only; VGB procedures are essentially no longer performed. The upper part of the stomach is stapled to create a narrow gastric inlet or pouch that remains connected with the remainder of the stomach. A non-adjustable band is also placed around the new inlet in an attempt to prevent future enlargement of the stoma/opening. Patients thus experience a sense of fullness after eating small meals. Weight loss from this procedure results entirely from eating less.

## COVERAGE POLICY

Pediatric Bariatric Surgery **is considered not medically necessary** and may not be authorized in persons who are under the age of 18 or in those who have not attained an adult level of physical development and maturation.<sup>1</sup>

**DOCUMENTATION REQUIREMENTS.** Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

## SUMMARY OF MEDICAL EVIDENCE

The body of evidence relating to bariatric surgery for treatment of severe obesity in adolescents is moderate in size and low in overall quality to assess the safety and/or impact on health outcomes or patient management. The evidence for bariatric surgery in adolescents with severe obesity is limited by the lack of large, well-designed clinical trials that provide data on long-term efficacy and safety of these surgeries. Small case series have shown some promising results but also indicate that the individuals regained most or all of their weight 5 to 10 years post-surgery. Systematic reviews and prospective cohort studies show concerns about possible nutritional deficiency in growing children and adolescents, and selection criteria for which surgical procedure is best and for appropriate surgical candidates are unclear. Additionally, the risks of complications, compliance and follow up are not well defined in the literature for the pediatric and adolescent population. Long-term, prospectively designed studies, with clear reporting of complications and co-morbidity resolution are needed to firmly establish the harms and benefits of bariatric surgery in children and adolescents.<sup>5-26</sup>

## SUPPLEMENTAL INFORMATION

None.

## CODING & BILLING INFORMATION

### Covered CPT Codes

CPT	Description
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 restrictive device (e.g., gastric band and subcutaneous port components)
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
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)
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

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	gastroplasty
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
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (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

**Covered HCPCS Code**

HCPCS	Description
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline

**Covered ICD-10 Codes**

ICD-10	Description
E 66.8	Other obesity
E66.01	Morbid severe obesity d/t excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug induced obesity
E66.9	Obesity unspecified
Z68.51	Body mass index BMI pediatric < 5th % for age
Z68.52	Body mass index BMI ped 5th % to < 85th % age
Z68.53	Body mass index BMI ped 85th % to < 95th % age
Z68.54	Body mass index ped >/equal to 95th % for age

**CODING DISCLAIMER.** Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

**APPROVAL HISTORY**

8/11/2021	Policy reviewed, no changes, updated references. No new evidence to change the non-coverage criteria for the pediatric and adolescent population.
7/10/2018, 6/19/2019, 6/17/2020	Policy reviewed, no changes.
3/8/2017	Policy reviewed, no changes. Updated the Summary of Medical Evidence section and references.
12/16/2015, 6/15/2016	Policy reviewed, no changes.
4/2/2014	Policy reviewed; no new evidence was found to change the non-coverage criteria for pediatric population.

**REFERENCES**

**Government Agencies**

- Centers for Medicare and Medicaid Services (CMS). Medicare coverage database (search “bariatric surgery treatment of morbid obesity NCD 100.1”). <http://www.cms.gov/mcd/search.asp>. Effective June 27, 2012. Accessed July 16, 2021.
- Food and Drug Administration (FDA). 510(k) premarket notification database: The lap-band® adjustable gastric banding system – summary of safety and effectiveness data. <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm>. Published February 16, 2011. Accessed July 16, 2021.
- Food and Drug Administration (FDA). 510(k) premarket notification database: ORBERA™ intragastric balloon system – summary of safety and effectiveness (no. P14008). <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm>. Published August 5, 2015. Accessed July 16, 2021.

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4. Food and Drug Administration (FDA). 510(k) premarket notification database: REALIZE™ adjustable gastric band model 2200-X – summary of safety and effectiveness (no. P070009). <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm>. Published September 28, 2007. Accessed July 16, 2021.

### Other Evidence Based Reviews and Publications

5. Advanced Medical Reviews (AMR) practicing, board-certified physician(s) in the areas of Surgery General, Surgery Vascular, Surgical Critical Care, Surgery. Updated January 31, 2014. Reviewed June 2020. Accessed July 12, 2021.
6. Hayes. Comparative effectiveness review: Bariatric surgeries for treatment of obesity in adolescents. <https://evidence.hayesinc.com>. Updated June 2020. Accessed July 16, 2021. Registration and login required.

### Peer Reviewed Publications

7. Xanthakos SA, Inge TH, Klish WJ, et al. Surgical management of severe obesity in adolescents. <http://www.uptodate.com>. Updated March 1, 2021. Accessed July 16, 2021. Registration and login required.
8. Alqahtani A, Elahmedi M, Qahtani AR. Laparoscopic Sleeve Gastrectomy in Children Younger Than 14 Years: Refuting the Concerns. *Ann Surg*. 2016 Feb;263(2):312-9. doi: 10.1097/SLA.0000000000001278. Accessed July 16, 2021.
9. Alqahtani AR, Elahmedi M, Qahtani AR, et al. Laparoscopic sleeve gastrectomy in children and adolescents with Prader-Willi syndrome: a matched-control study. *Surg Obes Relat Dis*. 2016 Jan;12(1):100-10. doi: 10.1016/j.soard.2015.07.014. Accessed July 16, 2021.
10. Bjornstad P, Nehus E, Jenkins T, et al. Five-year kidney outcomes of bariatric surgery differ in severely obese adolescents and adults with and without type 2 diabetes. *Kidney Int*. 2020 May;97(5):995-1005. doi: 10.1016/j.kint.2020.01.016. Accessed July 16, 2021.
11. Blumenfeld O, Beglaibter N, Geron N, et al. Comparative effectiveness of laparoscopic adjustable gastric banding vs laparoscopic sleeve gastrectomy in adolescents—a national registry-based study. *Obes Surg*. 2020 Jan;30(1):296-303. doi: 10.1007/s11695-019-04155-1. Accessed July 16, 2021.
12. Dewberry LC, Khoury JC, et al. Change in gastrointestinal symptoms over the first 5 years after bariatric surgery in a multicenter cohort of adolescents. *J Pediatr Surg*. 2019 Jun;54(6):1220-1225. doi: 10.1016/j.jpedsurg.2019.02.032. Accessed July 16, 2021.
13. Dewberry L, Khoury J, Schmiege S, Jenkins T, Boles R, Inge T. Gastrointestinal symptoms in relation to quality of life after metabolic surgery in adolescents. *Surg Obes Relat Dis*. 2020 Apr;16(4):554-561. doi: 10.1016/j.soard.2019.12.025. Accessed July 16, 2021.
14. Inge TH, Coley RY, Bazzano LA, et al. Comparative effectiveness of bariatric procedures among adolescents: The pcornt bariatric study. *Surg Obes Relat Dis*. 2018 Sep;14(9):1374-1386. doi: 10.1016/j.soard.2018.04.002. Accessed July 16, 2021.
15. Inge TH, Courcoulas AP, et al. Five-year outcomes of gastric bypass in adolescents as compared with adults. *N Engl J Med*. 2019 May 30;380(22):2136-2145. doi: 10.1056/NEJMoa1813909. Accessed July 16, 2021.
16. Inge TH, Courcoulas AP, Jenkins TM, et al. Weight loss and health status 3 years after bariatric surgery in adolescents. *N Engl J Med* 2016; 374:1133. doi: 10.1056/NEJMoa1506699. Accessed July 16, 2021.
17. Misra M, Singhal V, Carmine B, et al. Bone outcomes following sleeve gastrectomy in adolescents and young adults with obesity versus non-surgical controls. *Bone*. 2020 May;134:115290. doi: 10.1016/j.bone.2020.115290. Accessed July 16, 2021.
18. Paulus GF, de Vaan LE, Verdam FJ, et al. Bariatric surgery in morbidly obese adolescents: a systematic review and meta-analysis. *Obes Surg*. 2015 May;25(5):860-78. doi: 10.1007/s11695-015-1581-2. Accessed July 16, 2021.
19. Ruiz-Cota P, Bacardi-Gascon M, Jimenez-Cruz A. Long-term outcomes of metabolic and bariatric surgery in adolescents with severe obesity with a follow-up of at least 5 years: A systematic review. *Surg Obes Relat Dis*. 2019 Jan;15(1):133-144. doi: 10.1016/j.soard.2018.10.016. Accessed July 16, 2021.
20. Stanford FC, Mushannen T, Cortez P, et al. Comparison of short and long-term outcomes of metabolic and bariatric surgery in adolescents and adults. *Frontiers in endocrinology*. 2020;11:157. <https://www.frontiersin.org/journals/endocrinology>. Accessed July 16, 2021.
21. Xanthakos SA, Khoury JC, Inge TH, et al. Nutritional risks in adolescents after bariatric surgery. *Clin Gastroenterol Hepatol*. 2020 May;18(5):1070-1081.e5. doi: 10.1016/j.cgh.2019.10.048. Accessed July 16, 2021.
22. Zitsman JL, DiGiorgi MF, Zhang AZ, et al. Adolescent gastric banding: A 5-year longitudinal study. *Obes Surg*. 2020 Mar;30(3):828-836. doi: 10.1007/s11695-019-04321-5. Accessed July 16, 2021.

### National and Specialty Organizations

23. Bolling CF, Armstrong SC, Reichard KW, Michalsky MP, American Academy of Pediatrics (AAP) Sections on Obesity and Surgery. Policy statement: Metabolic and bariatric surgery for pediatric patients with severe obesity. *Pediatrics*. December 2019, 144 (6) e20193224. <https://doi.org/10.1542/peds.2019-3224>. Accessed July 16, 2021.
24. American Society for Bariatric Surgery (ASBS). Guidelines on bariatric surgery. <https://asmbs.org/resource-categories/guidelines-recommendations>. Published August 2018. Accessed July 16, 2021.
25. American Society for Metabolic and Bariatric Surgery (ASMBS). Position statements: Pediatric metabolic and bariatric surgery guidelines. <https://asmbs.org/>. Published 2018. Accessed July 16, 2021.
26. Mechanick JL, Youdim A, Jones DB, 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 the American Society for Metabolic & Bariatric Surgery. *Surg Obes Relat Dis*. Mar-Apr 2013;9(2):159-91. doi: 10.1016/j.soard.2012.12.010. Accessed July 16, 2021.

## APPENDIX

**Reserved for State specific information (to be provided by the individual States, not Corporate). Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.**

### Washington

*If bariatric surgery is requested or prescribed under the Early Periodic Screening Development and Testing (EPSDT)*

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*program, it is evaluated as a covered service under EPSDT's standard of coverage that requires the service to be medically necessary, safe and effective and non – experimental.*