



MASSACHUSETTS

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Medical Policy

Medical and Surgical Management of Obesity including Anorexiant

Table of Contents

- [Policy: Commercial](#)
- [Coding Information](#)
- [Information Pertaining to All Policies](#)
- [Policy: Medicare](#)
- [Description](#)
- [References](#)
- [Authorization Information](#)
- [Policy History](#)

Policy Number: 379

BCBSA Reference Number: 7.01.47

Related Policies

- Gastroesophageal Reflux Surgeries, [#376](#)
- Gastric Electrical Stimulation, [#636](#)

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Surgical Management of Obesity Services Preauthorization Request Form

Providers must complete the form. [Click here for the Surgical Management of Obesity Services preauthorization request form \(#047\)](#).

Medical management of obesity may be **MEDICALLY NECESSARY**, including laboratory services and other diagnostic tests prescribed by the physician specialist, and nutritional counseling in accordance with the member's subscriber certificate.

The following bariatric surgeries may be **MEDICALLY NECESSARY** for obesity that has not responded to conservative measures in patients who meet the "Patient Selection Criteria" described in this policy:

The following bariatric surgery procedures may be considered medically necessary for the treatment of morbid obesity in adults who have failed weight loss by conservative measures. Bariatric surgery should be performed in appropriately selected patients, by surgeons who are adequately trained and experienced in the specific techniques used, and in institutions that support a comprehensive bariatric surgery program, including long-term monitoring and follow-up post-surgery.

- Open gastric bypass using a Roux-en-Y anastomosis
- Laparoscopic gastric bypass using a Roux-en-Y anastomosis
- Laparoscopic adjustable gastric banding
- Sleeve gastrectomy
- Open or laparoscopic biliopancreatic bypass (i.e., the Scopinaro procedure) with duodenal switch.

The following revision bariatric surgeries may be **MEDICALLY NECESSARY**:

- Revision surgery to address perioperative or late complications of a bariatric procedure including but not limited to the following:

- Staple-line failure
- Obstruction
- Stricture
- Non-absorption resulting in hypoglycemia or malnutrition, and
- Weight loss of 20% or more below ideal body weight.
- Revision of a primary bariatric procedure that has failed due to dilatation of the gastric pouch or dilation proximal to an adjustable gastric band (documented by upper gastrointestinal examination or endoscopy) if:
 - The initial procedure was successful in inducing weight loss prior to pouch dilation, AND
 - The patient has been compliant with a prescribed nutrition and exercise program, AND
 - The patient still meets criteria (BMI) for bariatric surgery.

Patient Selection Criteria

Adults over the age of 18 or who have documented complete bone growth are eligible for obesity surgery if **ALL** of the following criteria are met:

- The physician has indicated that the patient:
 - Is a well informed and motivated patient with acceptable operative risks, AND
 - Has a strong desire for substantial weight loss, AND
 - Has failed other non-surgical approaches to long-term weight loss, AND
 - Is enrolled in a program which provides pre-op and post-op multidisciplinary evaluation and care including: behavioral health, nutrition, and medical management AND
- The patient is morbidly obese with a BMI > 40kg/m².

OR

- The patient has a BMI >35kg/m² and the physician has indicated that the patient has one or more of the following high risk co-morbid conditions:
 - Sleep apnea
 - Pickwickian syndrome
 - Pseudotumor cerebri
 - Obesity related cardiomyopathy
 - Type II Diabetes
 - At least Stage 1 Hypertension based on JNC-VII (SBP >140 and/or DBP >90) after combination pharmacotherapy
 - Coronary artery disease, or
 - Obesity related pulmonary hypertension.

Bariatric surgery in adolescents may be **MEDICALLY NECESSARY** according to the same weight-based criteria used for adults, but greater consideration should be given to psychosocial and informed consent issues. Patients must meet the “Patient Selection Criteria” described in this policy. In addition, any devices used for bariatric surgery must be in accordance with the FDA-approved indications for use.

The physician-directed visits and testing aspects of multi-faceted dietary programs such as Health Management Resources are considered **MEDICALLY NECESSARY**.

Non-physician directed and food replacement or supplement components of multi-faceted dietary programs such as Health Management Resources are considered **NOT MEDICALLY NECESSARY**.

The following medical and pharmaceutical treatments for obesity are considered **NOT MEDICALLY NECESSARY**:

- Multi-faceted dietary programs such as Optifast, and Medifast
- Orlistat [™] (Xenical [®]) because it may be purchased over the counter (alli [™]) without a prescription.
- Anorexiant and/or drugs to promote weight loss.

The following bariatric surgeries are considered **INVESTIGATIONAL** for managed care (HMO and POS), PPO, and Indemnity members:

- Vertical-banded gastroplasty,
- Gastric bypass using a Billroth II type of anastomosis (mini-gastric bypass),

- Biliopancreatic bypass without duodenal switch,
- Long limb gastric bypass (i.e., >150 cm),
- Two-stage bariatric surgery procedures (e.g., sleeve gastrectomy as initial procedure followed by biliopancreatic diversion at a later time),
- Endoscopic procedures (e.g., insertion of the StomaphyX™ device, EndoCinch suturing system) as a primary bariatric procedure or as a revision procedure, (i.e., to treat weight gain after bariatric surgery to remedy large gastric stoma or large gastric pouches),
- Jejunioileal bypass,
- Horizontal gastric partitioning/ gastroplasty,
- Gastric wrapping,
- Garren-Edwards gastric bubble,
- Gastric Electric Stimulation for the treatment of obesity (Gastric pacemaker), and Any bariatric surgery performed as a cure for type 2 diabetes mellitus.

Bariatric surgery for patients with a BMI less than 35 kg/m² is **INVESTIGATIONAL**.

Medicare HMO BlueSM and Medicare PPO BlueSM Members

Medical management of obesity may be covered, including laboratory services, other diagnostic tests prescribed by the physician specialist, and nutritional counseling in accordance with the member's subscriber certificate.

Intensive behavioral therapy for obesity (defined as a body mass index [BMI] greater than or equal to 30 kg/m²) is covered for the prevention or early detection of illness or disability. For patients who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting, the following services are covered:

- One face-to-face visit every week for the first month
- One face-to-face visit every other week for months 2-6,
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first six months as discussed below.

Intensive behavioral therapy for obesity consists of the following:

1. Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m²)
2. Dietary (nutritional) assessment, and
3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

At the six month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed. To be eligible for additional face-to-face visits occurring once a month for an additional six months, beneficiaries must have achieved a reduction in weight of at least 3kg over the course of the first six months of intensive therapy. This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice. For beneficiaries who do not achieve a weight loss of at least 3kg during the first six months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional six month period.

National Coverage Determination (NCD) for Intensive Behavioral Therapy for Obesity (210.12)

<http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=353&ncdver=1&bc=AgAAgAAAAAAAAAA%3d%3d&>

BCBSMA covers open and laparoscopic Roux-en-Y gastric bypass (RYGBP), open and laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS), and laparoscopic adjustable gastric banding (LAGB) for the following indications for Medicare HMO Blue and Medicare PPO Blue members in accordance with CMS NCD:

- Patients who have a body-mass index > 35, and
- Patients who have at least one co-morbidity related to obesity, and have been previously unsuccessful with medical treatment for obesity.

BCBSMA does not cover the following bariatric surgery procedures for Medicare HMO Blue and Medicare PPO Blue members in accordance with CMS NCD:

- Open adjustable gastric banding
- Open and laparoscopic sleeve gastrectomy (prior to June 27, 2012) and,
- Open and laparoscopic vertical banded gastroplasty.

BCBSMA covers stand-alone laparoscopic sleeve gastrectomy (LSG) for the treatment of co-morbid conditions related to obesity for Medicare HMO Blue and Medicare PPO Blue members in accordance with CMS NCD when ALL of the following conditions are satisfied:

- The beneficiary has a body-mass index (BMI) 35 kg/m²,
- The beneficiary has at least one co-morbidity related to obesity, and
- The beneficiary has been previously unsuccessful with medical treatment for obesity.

National Coverage Determination (NCD) for Bariatric Surgery for the Treatment of Morbid Obesity (100.1)

<http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=57&ncdver=4&DocID=100.1&bc=gAAAAAgAAAAAA%3d%3d&>

The following pharmaceutical treatments for obesity are considered **NOT MEDICALLY NECESSARY**:

- Orlistat™ (Xenical®) because it may be purchased over the counter (alli™) without a prescription.
- Anorexiant and/or drugs to promote weight loss.

Prior Authorization Information

Pre-service approval is required for all inpatient services for all products.

See below for situations where prior authorization may be required or may not be required.

Yes indicates that prior authorization is required.

No indicates that prior authorization is not required.

	Outpatient
Commercial Managed Care (HMO and POS)	n/a
Commercial PPO and Indemnity	n/a
Medicare HMO BlueSM	n/a
Medicare PPO BlueSM	n/a

CPT Codes / HCPCS Codes / ICD-9 Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member. A draft of future ICD-10 Coding related to this document, as it might look today, is included below for your reference.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

CPT codes:	Code Description
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve

	gastrectomy)
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded 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
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
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only

ICD-9 Diagnosis Codes

ICD-9-CM diagnosis codes:	Code Description
278.01	Morbid obesity
V85.35	Body Mass Index 35.0-35.9, adult
V85.36	Body Mass Index 36.0-36.9, adult
V85.37	Body Mass Index 37.0-37.9, adult
V85.38	Body Mass Index 38.0-38.9, adult
V85.39	Body Mass Index 39.0-39.9, adult
V85.41	Body Mass Index 40.0-44.9, adult
V85.42	Body Mass Index 45.0-49.9, adult
V85.43	Body Mass Index 50.0-59.9, adult
V85.44	Body Mass Index 60.0-69.9, adult
V85.45	Body Mass Index 70 and over, adult

ICD-9 Procedure Codes

When the following ICD 9 procedure codes are associated with the service(s) described in this document coverage for the service(s) is aligned with the policy statement.

ICD-9-CM procedure codes:	Code Description
43.82	Laparoscopic vertical (sleeve) gastrectomy
43.89	Open and other partial gastrectomy
44.31	High gastric bypass
44.38	Laparoscopic gastroenterostomy
44.39	Other gastroenterostomy without gastrectomy
44.5	Revision of gastric anastomosis
44.68	Laparoscopic gastroplasty
44.69	Other repair of stomach
44.95	Laparoscopic gastric restrictive procedure
44.96	Laparoscopic revision of gastric restrictive procedure
45.51	Isolation of segment of small intestine
45.91	Small-to-small intestinal anastomosis
46.79	Other repair of intestine

ICD-10 Diagnosis Codes

ICD-10-CM Diagnosis codes:	Code Description
E66.01	Morbid (severe) obesity due to excess calories
Z68.35	Body mass index (BMI) 35.0-35.9, adult
Z68.36	Body mass index (BMI) 36.0-36.9, adult
Z68.37	Body mass index (BMI) 37.0-37.9, adult
Z68.38	Body mass index (BMI) 38.0-38.9, adult
Z68.39	Body mass index (BMI) 39.0-39.9, adult
Z68.41	Body mass index (BMI) 40.0-44.9, adult
Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.43	Body mass index (BMI) 50-59.9 , adult
Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.45	Body mass index (BMI) 70 or greater, adult

ICD-10 Procedure Codes

ICD-10-PCS procedure codes:	Code Description
0DB64Z3	Excision of Stomach, Percutaneous Endoscopic Approach, Vertical
0D160ZA	Bypass Stomach to Jejunum, Open Approach
0D160ZB	Bypass Stomach to Ileum, Open Approach
0D164ZA	Bypass Stomach to Jejunum, Percutaneous Endoscopic Approach
0D164ZB	Bypass Stomach to Ileum, Percutaneous Endoscopic Approach
0D190ZB	Bypass Duodenum to Ileum, Open Approach
0D194ZB	Bypass Duodenum to Ileum, Percutaneous Endoscopic Approach
0DB60Z3	Excision of Stomach, Open Approach, Vertical
0DB60ZZ	Excision of Stomach, Open Approach
0DB80ZZ	Excision of Small Intestine, Open Approach
0DB90ZZ	Excision of Duodenum, Open Approach
0DBB0ZZ	Excision of Ileum, Open Approach
0DM60ZZ	Reattachment of Stomach, Open Approach
0DM64ZZ	Reattachment of Stomach, Percutaneous Endoscopic Approach
0DM80ZZ	Reattachment of Small Intestine, Open Approach
0DM84ZZ	Reattachment of Small Intestine, Percutaneous Endoscopic Approach
0DM90ZZ	Reattachment of Duodenum, Open Approach
0DM94ZZ	Reattachment of Duodenum, Percutaneous Endoscopic Approach
0DMA0ZZ	Reattachment of Jejunum, Open Approach
0DMA4ZZ	Reattachment of Jejunum, Percutaneous Endoscopic Approach
0DMB0ZZ	Reattachment of Ileum, Open Approach
0DMB4ZZ	Reattachment of Ileum, Percutaneous Endoscopic Approach
0DQ60ZZ	Repair Stomach, Open Approach
0DQ64ZZ	Repair Stomach, Percutaneous Endoscopic Approach
0DQ80ZZ	Repair Small Intestine, Open Approach
0DQ84ZZ	Repair Small Intestine, Percutaneous Endoscopic Approach
0DQ90ZZ	Repair Duodenum, Open Approach
0DQ94ZZ	Repair Duodenum, Percutaneous Endoscopic Approach
0DQA0ZZ	Repair Jejunum, Open Approach
0DQA4ZZ	Repair Jejunum, Percutaneous Endoscopic Approach
0DQB0ZZ	Repair Ileum, Open Approach
0DQB4ZZ	Repair Ileum, Percutaneous Endoscopic Approach

0DV60CZ	Restriction of Stomach with Extraluminal Device, Open Approach
0DV64CZ	Restriction of Stomach with Extraluminal Device, Percutaneous Endoscopic Approach
0DW64CZ	Revision of Extraluminal Device in Stomach, Percutaneous Endoscopic Approach

Description

Morbid obesity is defined as a body mass index (BMI) greater than 40 kg/m² or a BMI greater than 35 kg/m² with associated complications including, but not limited to diabetes, hypertension, or obstructive sleep apnea. Morbid obesity results in a very high risk for weight-related complications, such as diabetes, hypertension, obstructive sleep apnea, and various types of cancers (for men: colon, rectum, and prostate; for women: breast, uterus, and ovaries), and a shortened life span.

The first treatment of morbid obesity is dietary and lifestyle changes. Although this strategy may be effective in some patients, only a few morbidly obese individuals can reduce and control weight through diet and exercise. When conservative measures fail, some patients may consider surgical approaches. Bariatric surgery is performed for the treatment of morbid (clinically severe) obesity. Bariatric surgical procedures, fall into 2 general categories:

Gastric-restrictive procedures that create a small gastric pouch, resulting in weight loss by producing early satiety and thus decreasing dietary intake, and

Malabsorptive procedures, which produce weight loss due to malabsorption by altering the normal transit of ingested food through the intestinal tract. Some bariatric procedures may include both a restrictive and a malabsorptive component.

The following summarizes the different restrictive and malabsorptive procedures.

Gastric Restrictive Procedures

1. Vertical-Banded Gastroplasty

Vertical-banded gastroplasty was formerly one of the most common gastric restrictive procedures performed in this country but has more recently declined in popularity. In this procedure, the stomach is segmented along its vertical axis. To create a durable reinforced and rate-limiting stoma at the distal end of the pouch, a plug of stomach is removed, and a propylene collar is placed through this hole and then stapled to itself. Because the normal flow of food is preserved, metabolic complications are uncommon. Complications include esophageal reflux, dilation, or obstruction of the stoma, with the latter two requiring reoperation. Dilation of the stoma is a common reason for weight regain. Vertical-banded gastroplasty may be performed using an open or laparoscopic approach.

2. Open or Laparoscopic Gastric Bypass

The current procedure involves both a restrictive and a malabsorptive component, with horizontal or vertical partition of the stomach performed in association with a Roux-en-Y procedure (i.e., a gastrojejunal anastomosis). Thus, the flow of food bypasses the duodenum and proximal small bowel. The procedure may also be associated with an unpleasant “dumping syndrome,” in which a large osmotic load delivered directly to the jejunum from the stomach produces abdominal pain and/or vomiting. Because the normal flow of food is disrupted, there are more metabolic complications compared to other gastric restrictive procedures, including iron deficiency anemia, vitamin B-12 deficiency, and hypocalcemia, all of which can be corrected by oral supplementation. Gastric bypass may be performed with either an open or laparoscopic technique.

3. Adjustable Gastric Banding

Adjustable gastric banding involves placing a gastric band around the exterior of the stomach. The band is attached to a reservoir that is implanted subcutaneously in the rectus sheath. Injecting the reservoir with saline will alter the diameter of the gastric band; therefore, the rate-limiting stoma in the stomach can be progressively narrowed to induce greater weight loss, or expanded if complications develop. Because the stomach is not entered, the surgery and any revisions, if necessary, are relatively simple. Complications include slippage of the external band or band erosion through the gastric wall.

4. Sleeve gastrectomy

A sleeve gastrectomy is an alternative approach to gastrectomy that can be performed on its own, or in combination with malabsorptive procedures (most commonly biliopancreatic diversion with duodenal switch). In this procedure, the greater curvature of the stomach is resected from the angle of His to the distal antrum, resulting in a stomach remnant shaped like a tube or sleeve. The pyloric sphincter is preserved, resulting in a more physiologic transit of food from the stomach to the duodenum and avoiding the dumping syndrome that is seen with distal gastrectomy. This procedure is relatively simple to perform, and can be done as an open or laparoscopic procedure.

Malabsorptive Procedures

1. Biliopancreatic Bypass Procedure (also known as the Scopinaro procedure)

Biliopancreatic bypass (BPB) procedure consists of a subtotal gastrectomy and diversion of the biliopancreatic juices into the distal ileum by a long Roux-en-Y procedure. The procedure consists of the following components:

- A distal gastrectomy induces a temporary early satiety and/or the dumping syndrome in the early postoperative period, both of which limit food intake.
- A 200-cm long “alimentary tract” consists of 200 cm of ileum connecting the stomach to a common distal segment.
- A 300- to 400-cm “biliary tract” connects the duodenum, jejunum, and remaining ileum to the common distal segment.
- A 50- to 100-cm “common tract” is where food from the alimentary tract mixes with biliopancreatic juices from the biliary tract. Food digestion and absorption, particularly of fats and starches, are therefore limited to this small segment of bowel, i.e., creating a selective malabsorption. The length of the common segment will influence the degree of malabsorption.
- Because of the high incidence of cholelithiasis associated with the procedure, patients typically undergo an associated cholecystectomy.

Many potential metabolic complications are related to biliopancreatic bypass, including most prominently iron deficiency anemia, protein malnutrition, hypocalcemia, and bone demineralization. Protein malnutrition may require treatment with total parenteral nutrition. In addition, there have been several case reports of liver failure resulting in death or liver transplant.

2. Biliopancreatic Bypass with Duodenal Switch

The duodenal switch procedure is essentially a variant of the biliopancreatic bypass described above. In this procedure, instead of performing a distal gastrectomy, a sleeve gastrectomy is performed along the vertical axis of the stomach. This approach preserves the pylorus and initial segment of the duodenum, which is then anastomosed to a segment of the ileum, similar to the biliopancreatic bypass, to create the alimentary limb. Preservation of the pyloric sphincter is intended to ameliorate the dumping syndrome and decrease the incidence of ulcers at the duodenoileal anastomosis by providing a more physiologic transfer of stomach contents to the duodenum.

Summary

There is a very large body of literature on bariatric surgery, but few high-quality RCTs. The available evidence, largely from non-randomized comparative studies and case series, supports the conclusion that bariatric surgery results in greater weight loss and improvements in weight-related comorbidity compared to nonsurgical treatments. Gastric bypass, performed by either the open or laparoscopic approach, improves health outcomes of morbidly obese patients by leading to substantial weight loss with relatively low rates of adverse events. Gastric bypass accounts for more than 80% of bariatric operations performed in the United States and is considered the reference standard to which other procedures should be compared. There is also sufficient evidence that laparoscopic gastric banding, sleeve gastrectomy, and biliopancreatic diversion with duodenal switch improve outcomes. For these procedures compared to gastric bypass, there is a tradeoff in terms of the amount of weight loss, short-term complications, and long-term complications. An informed choice between patients and surgeons should be made after a thorough consideration of the risks and benefits of each procedure. Other bariatric surgery procedures remain investigational, as listed in the policy statement.

Limited evidence is available on bariatric surgery in patients with a BMI of less than 35. Case series report a high rate of remission of diabetes in undergoing gastric bypass surgery, and this indication was judged to meet the TEC criteria in 2012. However, bariatric surgery for diabetes in patients with a BMI less than 35 is not currently considered standard of care and is not supported in current specialty society guidelines. For patients without diabetes, there is limited evidence on outcomes of surgery and no evidence that health outcomes are improved. As a result, bariatric surgery for patients with a BMI less than 35 is investigational.

Bariatric surgery for adolescents is considered medically necessary using the same indications as for adults. However, greater consideration should be placed on the development stage of the patient, the psychosocial aspects of obesity and surgery, and on ensuring that the patient is able to provide fully informed consent.

To achieve optimal outcomes following bariatric surgery, similar to those reported in the literature from large bariatric surgery centers, certain conditions should be met. Careful patient selection and thorough pre-operative screening are essential. Surgeons need to be adequately trained in the particular techniques and should perform a high volume of these procedures. The institution should provide a full range of ancillary services, such as nursing and psychological support, and should provide for life-long follow-up after surgery. These conditions are best attainable as part of a dedicated, comprehensive bariatric surgery program that focuses on multidisciplinary care of the bariatric surgery patient.

Policy History

Date	Action
10/2014	Language on Health Management Resources clarified.
9/2014	Clarified coding information. Surgical Management of Obesity Services Preauthorization Request Form transferred to #047.
6/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
3/2014	BCBSA National medical policy review. Language added to policy statement on revision surgery to include complications of laparoscopic adjustable gastric banding. Effective 3/1/2014.
11/2013	Removed facility certification requirement for coverage of covered bariatric surgery procedures for Medicare Advantage. Effective 9/24/2013.
4/2013	Added coverage for stand-alone laparoscopic sleeve gastrectomy for Medicare HMO Blue and Medicare PPO Blue members. Retroactive to June 27, 2012.
4/2013	BCBSA National medical policy review. Changes to policy statement. Effective 4/1/2013.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
1/2012	BCBSA National medical policy review. Changes to policy statements.
5/2011	Reviewed - Medical Policy Group - Pediatrics and Endocrinology. No changes to policy statements.
11/2010	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
11/2010	BCBSA National medical policy review. Changes to policy statements.
2/2010	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
11/2009	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
3/2010	Review of Medicare NCD. Changes to policy statement.
11/2009	BCBSA National medical policy review.

	Changes to policy statements.
2/2009	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
11/2008	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
9/2008	BCBSA National medical policy review. Changes to policy statements.
4/2008	BCBSA National medical policy review. Changes to policy statements.
2/2008	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
5/2007	BCBSA National medical policy review. Changes to policy statements.
2/2007	Reviewed - Medical Policy Group - Psychiatry and Ophthalmology. No changes to policy statements.
5/1996	New policy, effective 5/1996, describing covered and non-covered indications.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

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