Independence

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Medical Policy Bulletin

Title:

Bariatric Surgery

Policy #:

11.03.02v

This policy is applicable to the Company's commercial products only. Policies that are applicable to the Company's Medicare Advantage products are accessible via a separate Medicare Advantage policy database.

The Company makes decisions on coverage based on Policy Bulletins, benefit plan documents, and the member's medical history and condition. Benefits may vary based on contract, and individual member benefits must be verified. The Company determines medical necessity only if the benefit exists and no contract exclusions are applicable.

When services can be administered in various settings, the Company reserves the right to reimburse only those services that are furnished in the most appropriate and cost-effective setting that is appropriate to the member's medical needs and condition. This decision is based on the member's current medical condition and any required monitoring or additional services that may coincide with the delivery of this service.

This Medical Policy Bulletin document describes the status of medical technology at the time the document was developed. Since that time, new technology may have emerged or new medical literature may have been published. This Medical Policy Bulletin will be reviewed regularly and be updated as scientific and medical literature becomes available. For more information on how Medical Policy Bulletins are developed, go to the Policy Types and Descriptions section of this Medical Policy Web site.

Policy

Coverage is subject to the terms, conditions, and limitations of the member's contract.

ADULT CRITERIA

MEDICALLY NECESSARY
Bariatric surgery for morbid obesity (Class III obesity) or a body mass index (BMI) of greater than 30 kg/m^2 (27.5 kg/m^2 or higher in individuals with Asian ethnicity) with type 2 diabetes mellitus is considered medically necessary and, therefore, covered for individuals who are 18 years of age or older when **all** of the following criteria are met:

- The individual has any of the following:
  - BMI ≥40 (BMI ≥37.5 kg/m^2 in individuals with Asian ethnicity)

- BMI between 35 and < 40 (BMI 32.5–37.4 kg/m^2 in individuals with Asian ethnicity) in conjunction with one or more comorbidities related to obesity (e.g., refractory hypertension, coronary artery disease, clinically significant obstructive sleep apnea, pseudotumor cerebri, severe nonalcoholic steatohepatitis [NASH]) for which the individual is receiving active treatment.

- The individual has a documented failed history of medical weight loss by conservative measures, and has participated in an intensive multicomponent behavioral intervention designed to help participants achieve or maintain weight loss through a combination of dietary changes and increased physical activity.
  - The intensive multicomponent behavioral intervention program must have components focusing on nutrition, physical activity, and behavioral modification (e.g., self-monitoring, identifying barriers, and problem solving). The multicomponent behavioral intervention program may be supervised by behavioral therapists, psychologists, registered dietitians, exercise physiologists, lifestyle coaches or other qualified professional providers.
- The individual is not currently pregnant and/or breast feeding and has agreed to avoid pregnancy for at least one year postoperatively.
- The individual has participated in preoperative surgical care, directed, and provided by the member's professional provider or through a multidisciplinary surgical preparatory regimen, including all of the following components:
  - A thorough medical history and physical examination
  - Consultation and instruction by a professional provider on low-calorie diets and an exercise program based on the individual's capability
  - An evaluation by a licensed mental health professional provider that specifically evaluates all of the following: any mental health or substance abuse conditions; the emotional readiness and ability of the individual to make and sustain lifestyle changes; and the adequacy of the individual's support system
- The individual is scheduled for one of the following surgeries:
  - Adjustable gastric banding, laparoscopic
  - Sleeve gastrectom, laparoscopic or open
  - Roux-en-Y gastric bypass with long limb (distal) (>150 cm), laparoscopic or open
  - Roux-en-Y gastric bypass with short limb (proximal) (≤150 cm), laparoscopic or open
  - Biliopancreatic diversion, laparoscopic or open
  - Biliopancreatic bypass (i.e., Scopinaro procedure), with duodenal switch

ADOLESCENT CRITERIA

MEDICALLY NECESSARY
Bariatric surgery for morbid obesity (Class III obesity) is considered medically necessary and, therefore, covered for individuals who are younger than 18 years of age when all of the following criteria are met:

- The individual has any of the following:
  - BMI ≥40 kg/m^2 (BMI ≥37.5 kg/m^2 in individuals with Asian ethnicity) or 140% of the 95th percentile for age and sex, whichever is lower
  - BMI between 35 and < 40 kg/m2 (BMI 32.5–37.4 kg/m^2 in individuals with Asian ethnicity) or 120% of the 95th percentile for age and sex, whichever is lower with at least one clinically significant obesity-related comorbidity, including but not limited to the following:
    - Coronary artery disease
    - Diabetes mellitus
    - Idiopathic intracranial hypertension
    - Poorly controlled hypertension (systolic blood pressure at least 140 mm Hg or diastolic blood pressure 90 mm Hg or greater, despite optimal medical management)
    - Obstructive sleep apnea
    - Gastroesophageal reflux
    - NASH
- The individual has a documented failed history of medical weight loss by conservative measures
- The individual is not currently pregnant and/or breastfeeding and has agreed to avoid pregnancy for at least 1 year postoperatively

- The individual has participated in preoperative surgical care, directed and provided by the member's professional provider or through a multidisciplinary surgical preparatory regimen, including all of the following components:
  - A thorough medical history and physical examination
  - Consultation and instruction by a professional provider on low-calorie diets and an exercise program based on the individual's capability
  - An evaluation by a licensed mental health professional provider specializing in pediatric care that specifically evaluates all of the following: any mental health or substance abuse conditions; the emotional readiness and ability of the individual to make and sustain lifestyle changes; and the adequacy of the individual's support system
- The individual has attained or nearly attained physiologic maturity as defined by one of the following:
  - Tanner Stage IV (skeletal and sexual maturation is almost complete [Refer to Attachment B for the Tanner Staging System criteria.])
  - Ninety-five percent of adult height based on estimates from radiologic bone age
- The individual is scheduled for, e.g., one of the following surgeries:
  - Roux-en-Y gastric bypass with short limb (proximal) (≤150 cm) (laparoscopic)
  - Roux-en-Y gastric bypass with long limb (distal) (>150 cm) (laparoscopic)
  - Sleeve gastrectomy, laparoscopic or open
  - Laparoscopic adjustable gastric banding

CONCOMITANT CHOLECYSTECTOMY

Cholecystectomy performed in conjunction with a medically necessary bariatric surgical procedure (listed above) is considered medically necessary and, therefore, covered when the individual has any of the following:

- Signs and/or symptoms of gallbladder disease
- Finding of a grossly diseased gallbladder at the time of bariatric surgery
- A history of metabolic derangements that will result in symptomatic gallbladder disease following a bariatric procedure

CONCOMITANT HIATAL HERNIA REPAIR WITH BARIATRIC SURGERY

Repair of a hiatal hernia at the time of bariatric surgery is considered medically necessary and, therefore, covered for individuals who have a preoperatively diagnosed hiatal hernia with indications for surgical repair.

COMPLICATIONS

The treatment of medical and surgical complications is considered medically necessary and, therefore, covered when, if left untreated, the complications would endanger the health of the individual.

Complications of a bariatric surgery procedure may include those associated with any major surgery such as bleeding or infection, but may also include those specific to the bariatric procedure itself or the method (e.g., laparoscopic, open) used. Complications associated with bariatric surgery (including those resulting from a technical failure) usually occur during the 30-day period following the operation. The most common complications include, but are not limited to:

- Band erosion
- Band slippage
- Internal hernia requiring further surgery
- Leaks from or dehiscence of anastomoses or staple lines
- Separation of stapled/sutured areas
- Wound separations
- Strictures
- Ulcers

- Nutritional deficiencies

SECOND BARIATRIC SURGICAL PROCEDURES

The following procedures are considered medically necessary for members who meet medical necessity criteria for their initial bariatric surgery, if they are NOT specifically excluded under the terms of the member's benefit contract:

- Conversion (e.g., to a Roux-en-Y gastric bypass or vertical gastrectomy) for members who have not had adequate success (defined as loss of >50 percent of excess body weight) following the primary bariatric surgery procedure and who have been compliant with a prescribed nutrition and exercise program following the initial procedure (documented in the letter of medical necessity). In addition, the member must have been examined by a licensed mental health professional provider that specifically evaluates all of the following: any mental health or substance abuse conditions, the emotional readiness and ability of the individual to make and sustain lifestyle changes, and the adequacy of the individual's support system.
- Conversion of sleeve gastrectomy to Roux-en-Y gastric bypass is considered medically necessary and, therefore, covered for the treatment of symptomatic and severe gastroesophageal reflux disease (GERD) meeting the following criteria:

    1. Reflux is documented by abnormal 24-hour pH monitoring or endoscopically and biopsy-proven esophagitis performed after the sleeve gastrectomy; and
    2. Symptoms persist despite optimal medical therapy, including behavioral modification and at least 1 month of twice-daily proton pump inhibitor (PPI) therapy.

- Revision surgery to address perioperative or late complications of a bariatric procedure, including but not limited to staple line failure, obstruction, stricture, nonabsorption resulting in hypoglycemia or malnutrition, weight loss of 20% or more below ideal body weight, and band slippage that cannot be corrected with manipulation or adjustment (documented in the letter of medical necessity)
- Replacement of an adjustable gastric band due to complications (e.g., port leakage, slippage, dilation proximal to the band), which is documented by upper gastrointestinal examination or endoscopy, that cannot be corrected with band manipulation or adjustments
- The second stage of a covered two-stage procedure (sleeve gastrectomy and duodenal switch; sleeve gastrectomy and gastric bypass)

For information on benefit limitations, please refer to the Guidelines section of this policy.

EXPERIMENTAL/INVESTIGATIONAL

Bariatric surgery for adult and adolescent individuals who do not meet the medical necessity criteria above is considered experimental/investigational and, therefore, not covered because the safety and/or effectiveness cannot be established by review of the available published peer-reviewed literature.

Bariatric surgery for preadolescent individuals is considered experimental/investigational and, therefore, not covered because the safety and/or effectiveness cannot be established by review of the available published peer-reviewed literature.

The following bariatric surgery and related procedures (not an all-inclusive list), are considered experimental/investigational and, therefore, not covered because their safety and/or effectiveness cannot be established by review of the available published peer-reviewed literature:

- Gastric balloon
- Malabsorption (regulatory metabolic) surgeries (e.g., jejunoileal bypass, jejunocolic bypass), laparoscopic or open
- Mini-gastric bypass, laparoscopic or open
- Vertical-banded gastroplasty, laparoscopic vertical-banded gastroplasty, VBG

CONCOMITANT CHOLECYSTECTOMY

Other than as detailed above as medically necessary, cholecystectomy performed in conjunction with a bariatric surgical procedure is considered experimental/investigational and, therefore, not covered because the safety and/or effectiveness cannot be established by review of the available published peer-reviewed literature.

CONCOMITANT HIATAL HERNIA REPAIR WITH BARIATRIC SURGERY

Repair of a hiatal hernia that is diagnosed at the time of bariatric surgery, or repair of a preoperatively diagnosed hiatal hernia in individuals who do not have indications for surgical repair is considered experimental/investigational and, therefore, not covered because the safety and/or effectiveness cannot be established by review of the available published peer-reviewed literature.

PLACE OF SERVICE

When services can be administered in various settings, the Company reserves the right to reimburse only those services that are furnished in the most cost-effective setting that is appropriate to the member's medical needs and condition. This decision is based on the member's current medical condition and any required monitoring or additional services that may coincide with the delivery of this service.

REQUIRED DOCUMENTATION

The individual's medical record must reflect the medical necessity for the care provided. These medical records may include, but are not limited to: records from the professional provider's office, hospital, nursing home, home health agencies, therapies, and test reports.

The Company may conduct reviews and audits of services to our members, regardless of the participation status of the provider. All documentation is to be available to the Company upon request. Failure to produce the requested information may result in a denial for the service.

At the time of precertification of the services listed below, the surgeon must submit a letter of medical necessity (LOMN), attesting that the member has been compliant with a prescribed nutrition and exercise program following the initial procedure.

Examples of services for which the LOMN is required:

- Conversion (e.g., to a Roux-en-Y gastric bypass or vertical gastrectomy) for members who have not had adequate success (defined as loss of >50% of excess body weight) 2 years following the initial bariatric surgery procedure.
- Revision surgery to address perioperative or late complications of a bariatric procedure, including but not limited to, staple line failure, obstruction, stricture, nonabsorption resulting in hypoglycemia or malnutrition, weight loss of 20% or more below ideal body weight, and band slippage that cannot be corrected with manipulation or adjustment.

Guidelines

BARIATRIC SURGERY SELECTION

Class III obesity, formerly known as morbid obesity, is defined as a body mass index (BMI) 40 kg/m^2 or more or a BMI 35 kg/m^2 or more with at least one clinically significant obesity-related disease such as type 2 diabetes (T2D), obstructive sleep apnea, coronary artery disease, or hypertension for which these complications or diseases are not controlled by best practice medical management. However, no evidence-based guidance has been identified that explicitly defines thresholds for determining the clinical significance of obesity-related disease that would qualify individuals for bariatric surgery. Additionally, a 2022 joint statement by the American

Society for Metabolic and Bariatric Surgery (ASMBS) and the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) recommends metabolic and bariatric surgery in individuals with a BMI greater than or equal to 35 kg/m^2, regardless of the presence, absence, or severity of comorbidities. This recommendation is based on nonrandomized, single-arm, single-center clinical studies described in detail in the Rationale section and briefly in the Background section; these include Gloy et al. (2013), Puzziferri et al. (2014), and the Swedish Obese Subjects (SOS) (Sjöström et al., 1999, 2004, 2007, 2012) trials. However, as these studies did not separately evaluate outcomes in individuals without comorbidities, evidence of the net health outcome in individuals without comorbidities is inconclusive.

Although there is limited evidence on which to assess the long-term impacts of bariatric surgery for patients younger than age 18 years, severely obese (class III obesity, BMI ≥40 kg/m^2 or 140% of the 95th percentile for age and sex, whichever is lower) adolescents with commonly present though not required comorbidities, or who have a BMI of 35 kg/m^2 or greater (class II obesity or 120% of the 95th percentile for age and sex, whichever is lower) with clinically significant disease (including, but not limited to, T2D, idiopathic intracranial hypertension, nonalcoholic steatohepatitis, Blount disease, slipped capital femoral epiphysis, gastroesophageal reflux disease, obstructive sleep apnea [apnea-hypopnea index >5], cardiovascular disease risks [HTN], hyperlipidemia, insulin resistance], depressed health-related quality of life) may be considered for bariatric surgery according to the American Academy of Pediatrics (Armstrong et al., 2019 and Hampl et al., 2023). US Food and Drug Administration (FDA) premarket approval for the LAP-BAND® System indicates it is intended for severely obese adults. (The clinical study submitted to FDA for approval of the LAP-BAND was restricted to adults ages 18 to 55 years.)

Patients should have documented failure to respond to conservative measures for weight reduction prior to consideration of bariatric surgery, and these attempts should be reviewed by the practitioner prior to seeking approval for the surgical procedure. As a result, some centers require active participation in a formal weight reduction program that includes frequent documentation of weight, dietary regimen, and exercise. However, there is a lack of evidence on the optimal timing, intensity, and duration of nonsurgical attempts at weight loss, and whether a medical weight loss program immediately preceding surgery improves outcomes.

Patients with a BMI of 50 kg/m^2 or more need a bariatric procedure to achieve greater weight loss. Thus, the use of adjustable gastric banding, which results in less weight loss, should be most useful as a procedure for patients with a BMI less than 50 kg/m^2. Malabsorptive procedures, although they produce more dramatic weight loss, potentially result in nutritional complications, and the risks and benefits of these procedures must be carefully weighed in light of the treatment goals for each patient. Patients who undergo adjustable gastric banding and fail to achieve adequate weight loss must show evidence of postoperative compliance with diet and regular bariatric visits prior to consideration of a second bariatric procedure.

BARIATRIC PROCEDURE CONSIDERATIONS

Of note, vertical-banded gastroplasty (VBG) is a purely restrictive procedure that is largely not performed in the United States and has been replaced by laparoscopic adjustable gastric banding (LAGB) or sleeve gastrectomy (SG). Weight loss with VBG is substantial, but there are high rates of revisions and reoperations due to staple line disruption, perforation, band erosion or disruption, and stenosis at the band site. Overall rates of revisions and reoperations at up to 10 years may be as high as 50% (Balsiger et al., 2000; Miller et al., 2007). VBG is not included on the list of endorsed procedures by the ASMBS (https://asmbs.org/resources/endorsed-procedures-and-devices).

CONSIDERATIONS FOR BARIATRIC SURGERY IN ADOLESCENTS

Guidelines for bariatric surgery in adolescents are not uniform in that there is variability in weight-based criteria, ranging from a BMI of 35 kg/m^2 with comorbidities to a BMI of 50 kg/m^2. Most guidelines use weight-based criteria that parallel those for adults.

In addition to the weight-based criteria, there is greater emphasis on issues of developmental maturity, psychosocial status, and informed consent for adolescent patients. All guidelines mention these issues, but recommendations are not uniform. The following are examples from US guidelines published since 2013 that address issues of maturity and psychosocial status.

ENDOCRINE SOCIETY

- The child has attained Tanner 4 or 5 pubertal development and final or near-final adult height.
- Psychological evaluation confirms the stability and competence of the family unit.
- The patient demonstrates the ability to adhere to the principles of healthy dietary and activity habits (Styne et al., 2017).

BARIATRIC PROCEDURE GUIDELINES

The choice of procedure in adolescents may also differ from adults, but there is a lack of consensus in guidelines or expert opinion as to the preferred procedure(s) for adolescents. The following factors should be considered in the choice of bariatric surgery in adolescents (Aikenhead et al., 2011):

- As in adults, laparoscopic gastric bypass is the most common procedure in adolescents.
- Devices used for LAGB do not have FDA approval in the United States for individuals younger than age 18 years.
- Some guidelines for bariatric surgery in adolescents do not recommend biliopancreatic diversions (BPD) because of the greater frequency of nutritional deficiencies on long-term follow-up, but other guidelines do not specify that BPD not be done in adolescents.

In 2018, the ASMBS published an updated guideline on pediatric metabolic and bariatric surgery (Pratt et al., 2018). With regard to choice of procedure, the guideline stated:

- "Vertical sleeve gastrectomy has become the most used and most recommended operation in adolescents with severe obesity for several reasons, near-equivalent weight loss to RYGB in adolescents, fewer reoperations, better iron absorption, and near-equivalent effect on comorbidities as RYGB in adolescents. However, given the more extensive long-term data available for RYGB, we can recommend the use of either RYGB or VSG in adolescents."

HIATAL HERNIA REPAIR GUIDELINES

In 2018, the ASMBS and the American Hernia Society published a consensus guideline on bariatric surgery and hernia surgery (Menzo et al., 2018). The guideline contained the following conclusions and summary recommendations:

- "There is a significant link between obesity and hernia formation both after abdominal surgery and de novo. There is also evidence that abdominal wall hernia can more commonly present with obstruction or strangulation in patients with obesity."
- "There is a higher risk for complications and recurrence after hernia repair in patients with obesity."
- "In patients with severe obesity and ventral hernia, and both being amenable to laparoscopic repair, combined hernia repair and metabolic/bariatric surgery may be safe and associated with good short-term outcomes and low risk of infection. There is a relative lack of evidence, however, about the use of synthetic mesh in this setting."
- "In patients with severe obesity and abdominal wall hernia that is not amenable to laparoscopic repair, a staged approach is recommended. Weight loss prior to hernia repair is likely to improve hernia repair outcomes. Metabolic/bariatric surgery appears to provide far more significant and rapid weight loss than other modalities and would be a good option for selected patients with severe obesity and large, symptomatic abdominal wall hernia."

The Society of American Gastrointestinal and Endoscopic Surgeons issued evidence-based guidelines for the management of hiatal hernia (Kohn et al., 2013). The Society noted that the general methodologic quality of available studies is low. Recommendations for indications for repair are as follows:

- “Repair of a type I hernia [sliding hiatal hernias, where the gastroesophageal junction migrates above the diaphragm in the absence of reflux disease is not necessary” (moderate-quality evidence, strong recommendation).

- “All symptomatic paraesophageal hiatal hernias should be repaired [high-quality evidence, strong recommendation], particularly those with acute obstructive symptoms or which have undergone volvulus.”
- “Routine elective repair of completely asymptomatic paraesophageal hernias may not always be indicated. Consideration for surgery should include the patient’s age and co-morbidities” (moderate-quality evidence, weak recommendation)."

Refer to the Coding Table for a list of diagnosis codes that represent a BMI of 35 or greater.

Inadequate weight loss or regain of weight is most commonly associated with an individual's noncompliance with postoperative nutrition and exercise recommendations. Individuals who experience inadequate weight loss or weight gain should be evaluated for technical failure of the surgical procedure. Contrast upper gastrointestinal examination is appropriate to ensure the integrity of the gastric reconstruction. Once technical failure of the operation has been excluded, individuals should be referred for dietary counseling.

Note: Surgical intervention in the treatment of obesity is an adjunct to an overall dietary plan and will not result in adequate weight loss in the absence of a conscious effort at dietary control.

BENEFIT APPLICATION

Subject to the terms and conditions of the applicable benefit contract, bariatric surgery is covered under the medical benefits of the Company’s products when the medical necessity criteria listed in this medical policy are met. However, services that are identified in this policy as experimental/investigational or not medically necessary are not eligible for coverage or reimbursement by the Company.

Services that are experimental/investigational are a benefit contract exclusion for all products of the Company. Therefore, they are not eligible for reimbursement consideration.

SECOND BARIATRIC SURGICAL PROCEDURES

Member benefit contracts may limit bariatric surgery to one surgical procedure per lifetime.

A prior bariatric surgery can be counted towards the lifetime limit under the following circumstances:

- Fully insured groups: the member is employed by the same employer and the same Carrier provides coverage (e.g., the member was employed by Employer ‘A’ at the time of the first surgery, which was covered by the Company. At the time of the request for the second surgery, the member is still employed by ‘A’ and the Company is still the Carrier). Please note that if the employer group changes Carriers, any surgery performed while the employed was covered by the earlier Carrier will not be counted toward the lifetime limit.
- Self-insured groups: the member is covered under the same group Health Plan (i.e., employer), but the employer changes claims administrators (e.g., the member was employed by Employer ‘A’ at the time of the first surgery and the Claims Administrator was not the Company. At the time of the request for the second surgery, the member is still employed by ‘A,’ but the Company is now the Claims Administrator).
- The employer changes its funding status (e.g., the member was employed by Employer ‘A,’ which was fully insured at the time of the first surgery; at the time of the request for the second surgery, the member is still employed by ‘A,’ but ‘A’ has changed its funding status to self-insured).
- The member changes products (e.g., the member was employed by Employer ‘A’ and enrolled in a Company HMO program at the time of the first surgery. At the time of the request for the second surgery, the member is still employed by ‘A,’ but is now enrolled in a Company PPO program).

Any new or different obesity surgery, revisions, repeat, or reversal of any previous surgery may not be covered even if the new or different procedure intended to treat obesity is medically necessary.

The limitation of coverage for a repeat, reversal, or revision of a previous obesity surgery does not apply when the initial procedure results in technical failure or when the proposed procedure is required to treat complications of the initial procedure, which if left untreated, would result in endangering the health of the individual.

Weight gain or weight plateau resulting from failure to follow the regimen of diet and exercise recommended after the first bariatric surgery would be excluded from coverage for a repeat, reversal, or revision of a previous obesity surgery because the second procedure is not being performed to treat a complication or technical failure of the initial procedure.

BILLING GUIDELINES

Psychiatric evaluations performed prior to bariatric surgery are covered under the member's medical benefit. Reimbursement for the evaluation is in accordance with the performing professional provider's contract.

Description

MORBID OBESITY (CLASS III OBESITY)

Obesity is an increase in body weight beyond the limitation of skeletal and physical requirements caused by an excessive accumulation of fat in the body. Morbid obesity, also referred to as clinically severe obesity and Class III obesity, refers to an individual with a BMI of 40 or greater, such as an individual who is 100 pounds over ideal weight.

Morbid obesity (Class III) is also categorized based on BMI with terms such as super-obese (BMI >50) and super-super obese (BMI >60). BMI is a measurement of excess adipose tissue in the body according to height and weight that is used to quantify body fat.

The immediate cause of obesity is a caloric intake that is persistently higher than caloric output. Obesity may also be caused by illnesses such as hypothyroidism, Cushing's disease, and hypothalamic lesions.

Morbid obesity (Class III) has been associated with cardiac disease, type 2 diabetes mellitus (T2D), obstructive sleep apnea (OSA), and various cancers. The initial treatment for morbid obesity (Class III) is usually medical management (MM) using conservative measures. MM to induce weight loss includes caloric restriction, increased physical activity, US Food and Drug Administration (FDA)–approved weight-loss agents, and behavioral modification.

Another method used for weight loss is supplemented fasting, which combines a low-calorie intake with a supplemented mixture of protein, carbohydrates, vitamins, and minerals. However, prolonged adherence to this diet (2 months or more) has resulted in undesirable results such as loss of body protein, cardiopathology, or, in some cases, sudden death. Therefore, supplemental fasting is not a standard treatment for morbid obesity.

When attempts to induce weight loss through the MM methods described above have failed, bariatric surgery is often considered as an intervention to treat morbid obesity. Current surgical procedures used for weight loss in morbidly obese (Class III) individuals have been noted to reduce medication use and, in some cases, eliminate T2D altogether in morbidly obese individuals. The same procedures have been proposed to treat T2D in individuals who are not morbidly obese. However, the available published peer-reviewed literature is insufficient to conclude that these procedures improve health outcomes in individuals who are not morbidly obese (i.e., those with BMI of <35). Refer to Attachment A in this policy for BMI charts.

Bariatric surgical procedures reduce caloric intake by modifying the anatomy of the gastrointestinal tract. These procedures are classified as follows:

- Restrictive procedures
- Gastric restriction combined with a diversionary procedure
- Diversionary malabsorptive procedures (regulatory metabolic)