Policy Statement

The medical necessity criteria in this document govern the appropriate use of bariatric surgery, which is a surgical procedure performed for the treatment of morbid obesity. Morbid obesity is defined as a body mass index (BMI) greater than 40 kg/m² or greater than 35 kg/m² with associated complications. Bariatric surgery in adults with morbid obesity may include the following bariatric surgery procedures when criteria are met:

- Open gastric bypass using a Roux-en-Y anastomosis (for patients with prior abdominal surgery only)
- Laparoscopic gastric bypass using a Roux-en-Y anastomosis
- Laparoscopic adjustable gastric banding
- Sleeve gastrectomy
- Open or laparoscopic biliopancreatic diversion (i.e., Scopinaro procedure) with duodenal switch

Initial Bariatric Procedure

Bariatric surgery for the treatment of morbid obesity may be considered medically necessary when all of the following criteria are met:

- The patient is an adult 18 years or older (see section below for adolescent patients) with morbid obesity, defined as either of the following:
  - A body mass index (BMI) greater than 40 kg/m²
  - A BMI greater than 35 kg/m² with at least one clinically significant obesity-related disease, including but not limited to:
    - Type 1 or 2 diabetes mellitus
    - Clinically significant obstructive sleep apnea (an apnea-hypopnea index [AHI] of at least 15 events per hour, or an AHI of at least 5 events per hour in a patient with excessive daytime sleepiness or hypertension) or obesity-hypoventilation syndrome
    - Coronary artery disease, with documentation of atherosclerotic heart disease as evidenced by any of the following:
      - Stress study
      - Coronary angiography
      - History of heart failure
      - History of myocardial infarction
      - Prior bypass
      - Prior percutaneous coronary intervention (PCI)
    - Hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic in spite of the concurrent use of 3 anti-hypertensive drugs, one of which may be a diuretic) (See Policy Guidelines section)
    - Painful or activity-limiting osteoarthritis involving the lower extremities, with radiographic documentation of joint space narrowing, osteophytes, subluxation, or subchondral sclerosis
    - Hyperlipidemia (LDL cholesterol of 160 mg/dL or higher), uncontrolled by diet and medical therapy
    - Gastroesophageal reflux disease (GERD), based on ambulatory pH probe monitoring, or endoscopic findings of ulcer, strictures, Barrett’s esophagus, or esophagitis and failing maximal medical therapy (e.g., proton pump inhibitors, H2 blockers, and/or prokinetic agents titrated to maximal recommended dosages)
  - The patient has failed weight loss to a BMI less than 35 kg/m² at the time of surgery by conservative (including pharmacologic) measures for 3 consecutive months in the past 12 months prior to consultation with the bariatric surgeon, despite one of the following:
o Documentation of participation in a structured physician-supervised weight-loss program including an exercise program as tolerated or available

o Serially-charted documentation, including notes from two clinician-directed follow-up visits, of participation in another managed weight-loss program including dietary control and exercise as tolerated or available (commercial, dietician, or diabetes management programs)

- The patient has been evaluated for, and has received, maximal therapy for any secondary (e.g., endocrine) causes of obesity, has been evaluated for and treated for any pulmonary, gastrointestinal (including GERD), neoplastic, and cardiac co-morbidities which may impact surgery, and has been medically cleared for surgery, as documented in the Pre-Operative Checklist

- The patient has received a comprehensive psychosocial-behavioral evaluation signed by a qualified mental health professional (see Policy Guidelines) clearing the patient for surgery, as documented in the Psychosocial-Behavioral Checklist

- The patient has undergone educational counseling or a formal class giving a comprehensive understanding of the available bariatric surgery procedures, of how the patient's life will be changed after surgery, the morbidity and mortality associated with this surgery, and the commitment required to make the lifestyle changes necessary to maintain the health improvements achieved through surgery

- The patient has reviewed, completed, and signed the Bariatric Surgery Decision Aid ensuring shared decision making has occurred (see Policy Guidelines section)

- The patient has reviewed, completed, and signed the “CollaboRATE” survey

- The bariatric surgery is performed by properly credentialed surgeons, and preferably at Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) accredited hospitals that follow the American Society for Metabolic and Bariatric Surgery (ASMBS) guidelines, including a multidisciplinary program experienced in obesity surgery that can provide all of the following:
  o Nutritional counseling
  o Exercise counseling
  o Long-term monitoring including both of the following:
    ▪ Psychosocial counseling
    ▪ Support group meetings

Revision Bariatric Surgery

The first (or a subsequent) revision surgery to address perioperative or late complications of a bariatric procedure may be considered medically necessary, provided that these complications include, but are not limited to:

- Staple-line failure or leakage
- Obstruction, stricture, erosion, or fistula
- Gastroesophageal reflux disease (GERD), based on ambulatory pH probe monitoring, or endoscopic findings of ulcer, strictures, Barrett’s esophagus, or esophagitis and failing maximal medical therapy
- Symptomatic pouch enlargement (recurrent vomiting or nausea)
- Nonabsorption resulting in hypoglycemia or malnutrition
- Weight loss of 20% or more below ideal body weight
- Band slippage or herniation that cannot be corrected with manipulation or adjustment

Revision of a primary or a subsequent bariatric procedure that has failed due to inadequate weight loss may be considered medically necessary when all of the following are met:

- All initial primary bariatric surgery qualification criteria have been satisfied, including:
  o BMI greater than 40, or BMI greater than 35 with comorbid condition for most recent 2 years
  o No recent (less than 1 year) treatment for drug abuse
  o No recent tobacco use (less than 6 weeks)
  o Psychologic clearance
  o Preoperative nutritional counseling
Participation in a medically managed exercise and dietary program for 3 consecutive months
- Ineffective weight loss attempts within 1 year prior to revision of surgery
- Two years have elapsed since prior bariatric surgery
- Inadequate weight loss resulted from initial procedure; less than 50% expected weight loss and/or weight remains greater than 40% over ideal body weight (normal body weight BMI parameter = 18.5-24.9)
- Compliance with previous post-operative nutrition plan and exercise program is documented

### Bariatric Surgery in Adolescents
Bariatric surgery in adolescents may be considered medically necessary according to the same weight-based criteria used for adults, but greater consideration should be given to psychosocial and informed consent issues (see Policy Guidelines section). Patients must otherwise meet all criteria in Initial Bariatric Procedure section, above. In addition, any devices used for bariatric surgery must be used in accordance with the U.S. Food and Drug Administration-approved indications.

### Bariatric Surgery in Preadolescent Children
Bariatric surgery is considered investigational for the treatment of morbid obesity in preadolescent children.

### Concomitant Hiatal Hernia Repair With Bariatric Surgery
Repair of a hiatal hernia at the time of bariatric surgery may be considered medically necessary for patients who have a preoperatively diagnosed hiatal hernia with indications for surgical repair (see Policy Guidelines section).

Repair of a hiatal hernia that is diagnosed at the time of bariatric surgery, or repair of a preoperatively diagnosed hiatal hernia in patients who do not have indications for surgical repair, is considered investigational.

### Other Bariatric Surgery Procedures
Any of the following bariatric surgery procedures are considered investigational for the treatment of morbid obesity in adults who have failed weight loss by conservative measures:
- Vertical-banded gastroplasty
- Gastric bypass using a Billroth II type of anastomosis (mini-gastric bypass)
- Biliopancreatic diversion without duodenal switch
- Long-limb gastric bypass procedure (i.e., greater than 150 cm)
- Single anastomosis duodenal bypass with sleeve gastrectomy
- Two-stage bariatric surgery procedures (e.g., sleeve gastrectomy as initial procedure followed by biliopancreatic diversion at a later time)
- Endoscopic procedures 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) including but not limited to:
  - Insertion of the StomaphyX™ device
  - Insertion of a gastric balloon
  - Endoscopic gastroplasty
  - Use of an endoscopically placed duodenolejunal sleeve
  - Laparoscopic gastric plication
  - Aspiration therapy device

### Bariatric Surgery Contraindications
Bariatric surgery is considered not medically necessary for any of the following:
- Patients with a body mass index less than or equal to 35 kg/m² at the time of surgery
- Patients who are pregnant
• Patients with typical major surgery contraindications (active infection, uncontrolled bleeding diathesis, device allergies, etc.)
• Patients with use of tobacco products (no use within 6 weeks), or with history of recent alcohol or drug abuse (no treatment for alcohol or drug abuse within 1 year)
• Patients with an untreated or uncontrolled DSM-5 psychiatric disorder limiting compliance with medical and dietary post-surgical requirements
• Patients unwilling to comply with post-surgical medical and dietary requirements and required follow-up appointments

**Policy Guidelines**

Clinicians performing bariatric surgery must have appropriate clinical training and experience and have satisfactory outcomes as assessed by quality assurance monitoring. Bariatric surgery must be performed in a manner consistent with established standards of care.

**Appropriate Use Criteria**

Appropriate use criteria are intended to assist patients and clinicians, but are not intended to diminish the acknowledged difficulty or uncertainty of clinical decision making and cannot act as substitutes for sound clinical judgment and practice experience.

**Decision Aids**

Use of decision aids can promote shared decision making, and may improve patients understanding and enable them to make decisions that are fully informed and consistent with their preferences, values and goals. A decision aid is a tool used to inform patients about available treatments, along with potential benefits, risks and costs, during clinical encounters. The decision aid is intended for use following the patient pre-operative education course. The resulting decision aid is intended to be nondirective, encouraging clinicians to create a conversation with patients using their own communication styles, while simultaneously ensuring that key information is conveyed and that patient preferences are elicited.

**Anti-Hypertensive Drug Classes**

Regimen may include a diuretic with 2 anti-hypertensive drugs of different classes.

**Recommendations from Qualified Mental Health Professionals**

The minimal credentials for qualified mental health professionals who work with adults presenting with a desire for bariatric surgery include a master's degree or its equivalent or a more advanced degree (e.g., Ph.D., M.D., Ed.D., D.Sc., D.S.W., Psy.D., LCSW, or MFT) in a clinical behavioral science field with established competence in the assessment of adults who desire bariatric surgery. At least one of the professionals must be capable of adequately evaluating comorbid psychiatric conditions.

**Bariatric Surgery in Children and Adolescents**

The evidence for bariatric surgery in patients younger than age 18 years consists primarily of studies of adolescents, with a lack of evidence for younger children. Guidelines for bariatric surgery in adolescents are not uniform, with variability in weight-based criteria, ranging from a BMI of 35 kg/m² with comorbidities to a BMI of 50 kg/m². Most guidelines use weight-based criteria that parallel those for adult patients.

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 for addressing them. The following are examples from U.S. guidelines that address issues of maturity and psychosocial status.

**Endocrine Society**

The 2017 Endocrine Society Clinical Practice Guideline on Pediatric Obesity suggest bariatric surgery only under the following conditions (Styne et al, 2017):
• “The patient has attained Tanner 4 or 5 pubertal development and final or near-final adult height, the patient has a BMI of >40 kg/m² or has a BMI of >35 kg/m² and significant, extreme comorbidities
• Extreme obesity and comorbidities persist despite compliance with a formal program of lifestyle modification, with or without pharmacotherapy
• Psychological evaluation confirms the stability and competence of the family unit, psychological distress due to impaired QOL from obesity may be present, but the patient does not have an underlying untreated psychiatric illness
• The patient demonstrates the ability to adhere to the principles of healthy dietary and activity habits
• The patient has access to an experienced surgeon in a pediatric bariatric surgery center of excellence providing the necessary infrastructure for patient care, including a team capable of long-term follow-up of the metabolic and psychosocial needs of the patient and family.”

Institute for Clinical Systems Improvement
The 2013 Health Care Guideline on Prevention and Management of Obesity for Children and Adolescents states that bariatric surgery should only be considered in the pediatric population under the following conditions (Fitch et al, 2013)123:
• BMI >40 kg/m² or BMI >35 kg/m² with a significant severe comorbidity (such as type 2 diabetes mellitus, obstructive sleep apnea, or pseudotumor cerebri).
• Attained Tanner 4 or 5 pubertal development or has a bone age of ≥13 years in females or ≥15 years in males.
• Failure of ≥6 months of organized weight management.
• Decisional capacity and commitment to comprehensive medical and psychological evaluation before and after surgery.
• Supportive family environment.

The choice of procedure in adolescents may also differ from adults, but there is a lack 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 laparoscopic adjustable gastric banding 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 because of the greater frequency of nutritional deficiencies on long-term follow-up, but other guidelines do not specify that biliopancreatic diversion not be done in adolescents.

Hiatal Hernia Repair Guidelines
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 comorbidities (moderate quality evidence, weak recommendation).”
Coding
Hiatal hernia repair performed at the time of bariatric surgery would not be reported with the hiatal hernia repair code. There is no code for this specific surgery, therefore, it should be reported with code 43289 - Unlisted laparoscopy procedure, esophagus.

Description
Bariatric surgery is a treatment for morbid obesity in patients who fail to lose weight with conservative measures. There are numerous surgical techniques available. These techniques have heterogenous mechanisms of action, with varying degrees of gastric restriction that create a small gastric pouch, which may lead to malabsorption of nutrients and metabolic changes, that result from gastric and intestinal surgery.

Related Policies
- Gastric Electrical Stimulation
- Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease

Benefit Application
Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates [e.g., Federal Employee Program (FEP)] prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status
Forms of bariatric surgery performed without specific implantable devices are surgical procedures and, as such, are not subject to regulation by the U.S. Food and Drug Administration (FDA).

Table 1 shows forms of bariatric surgery with implantable devices approved by the FDA through the premarket approval process.

Table 1. FDA-Approved Bariatric Surgery Devices

<table>
<thead>
<tr>
<th>Device</th>
<th>Manufacturer</th>
<th>PMA Date</th>
<th>Labeled Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>AspireAssist System</td>
<td>Aspire Bariatrics</td>
<td>Jun 2016</td>
<td>For long-term use in conjunction with lifestyle therapy and continuous medical monitoring in obese adults ≥22 y, with a BMI of 35.0 to 55.0 kg/m² and no contraindications to the procedure who have failed to achieve and maintain weight loss with nonsurgical weight loss therapy</td>
</tr>
<tr>
<td>ORBERA® Intragastric Balloon System</td>
<td>Apollo Endosurgery</td>
<td>Aug 2015</td>
<td>For use in obese adults (BMI, 30-40 kg/m²) who have failed weight reduction with diet and exercise, and have no contraindications. Maximum placement time is 6 mo. Balloon placed endoscopically and inflated with saline.</td>
</tr>
<tr>
<td>ReShape® Integrated Dual Balloon System</td>
<td>ReShape Medical</td>
<td>Jul 2015</td>
<td>For use in obese adults (BMI, 30-40 kg/m²) and ≥1 comorbid conditions who have failed weight reduction with diet and exercise, and have no contraindications. Maximum placement time is 6 mo. Balloon delivered transorally and inflated with saline.</td>
</tr>
</tbody>
</table>
Device | Manufacturer | PMA Date | Labeled Indications
--- | --- | --- | ---
LAP-BAND® Adjustable Gastric Banding System | Apollo Endosurgery (original applicant: Allergan) | Apr 2010 | For use in weight reduction for severely obese adults with BMI of at least 40 kg/m² or a BMI of at least 30 kg/m² with ≥1 severe comorbid conditions who have failed more conservative weight-reduction alternatives (e.g., supervised diet, exercise, behavior modification programs).

REALIZE® Adjustable Gastric Band | Ethicon Endosurgery | Nov 2007 | For use in weight reduction for morbidly obese patients and for individuals with BMI of at least 40 kg/m², or a BMI of at least 35 kg/m² with ≥1 comorbid conditions, or those who are ≥45.4 kg over their estimated ideal weight. Indicated for use only in morbidly obese adults who have failed more conservative weight-reduction alternatives (e.g., supervised diet, exercise, behavior modification programs).

BMI: body mass index; FDA: Food and Drug Administration; PMA: premarket approval.

In February 2017, the FDA issued a letter to health care providers discussing the potential risks associated with liquid-filled intragastric balloons in response to reports of 2 types of adverse events related to the balloons. Several dozen reports concerned spontaneous overinflation of the balloons, which caused pain, swelling, and vomiting. The second set of adverse event reports indicated that acute pancreatitis developed in several patients due to compression of gastrointestinal structures. These reports involved both ReShape and ORBERA brands. The adverse events may require premature removal of the balloons.

In August 2017, the FDA issued a second letter to health care providers informing them of 5 unanticipated deaths occurring from 2016 through the time of the letter, due to intragastric balloons. The FDA recommended close monitoring of patients receiving these devices.

Rationale

Background Bariatric Surgery

Bariatric surgery is performed to treat morbid (clinically severe) obesity. 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, rectal, prostate; for women: breast, uterine, ovarian), and a shortened lifespan. A morbidly obese man at age 20 can expect to live 13 fewer years than his counterpart with a normal BMI, which equates to a 22% reduction in life expectancy.

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. Most patients find it difficult to comply with these lifestyle modifications on a long-term basis.

When conservative measures fail, some patients may consider surgical approaches. A 1991 National Institutes of Health Consensus Conference defined surgical candidates as “those patients with a BMI of greater than 40 kg/m², or greater than 35 kg/m² in conjunction with severe comorbidities such as cardiopulmonary complications or severe diabetes.”

Resolution (cure) or improvement of type 2 diabetes after bariatric surgery and observations that glycemic control may improve immediately after surgery before a significant amount of weight is lost have promoted interest in a surgical approach to the treatment of type 2 diabetes. The various surgical procedures have different effects, and gastrointestinal rearrangement seems to confer additional antidiabetic benefits independent of weight loss and caloric restriction. The precise mechanisms are not clear, and multiple mechanisms may be involved. Gastrointestinal
peptides, e.g., glucagon-like peptide-1, glucose-dependent insulinotropic peptide, and peptide YY, are secreted in response to contact with unabsorbed nutrients and by vagally mediated parasympathetic neural mechanisms. Glucagon-like peptide-1 is secreted by the L cells of the distal ileum in response to ingested nutrients and acts on pancreatic islets to augment glucose-dependent insulin secretion. It also slows gastric emptying, which delays digestion, blunts postprandial glycemia, and acts on the central nervous system to induce satiety and decrease food intake. Other effects may improve insulin sensitivity. Glucose-dependent insulinotropic peptide acts on pancreatic beta cells to increase insulin secretion through the same mechanisms as glucagon-like peptide-1, although it is less potent. Peptide YY is also secreted by the L cells of the distal intestine and increases satiety and delays gastric emptying.

Bariatric surgery is commonly used to address the morbidity caused by obesity, but current evidence shows its present impact on the obesity epidemic may be far from optimal. The current approach to bariatric surgery does not explicitly result in successful outcomes for patients, as evidenced by numerous clinical guidelines and recent studies. The Institute for Clinical and Economic Review (ICER) issued a report in 2015, which indicated that ICER did not consider the evidence to provide high levels of certainty for bariatric surgery because of unfavorable long-term outcomes and the durability of clinical benefit. While the evidence for bariatric surgery showed a moderate level of certainty, ICER recommended that bariatric surgery should only be considered when weight loss management approaches have failed or have had insufficient benefit.

**Shared Decision Making**

Shared Decision Making (SDM) is a process in which patients openly explore with the aid of their physician both the available evidence supporting each therapeutic intervention, and also determine what matters most to the patient. This allows both the physician and the patient to reach agreed-upon treatment decisions reflecting mutual goals and expected outcomes. The completion of the CollaboRATE survey and signing of the bariatric surgery decision aid by the member helps to assure the member’s personal preferences have been considered.

**CollaboRATE**

Patient-centered health care is a central component of current health policy agendas. CollaboRATE is a 3-Item questionnaire that measures the level of shared decision making in the clinical encounter from the patient’s perspective. In the questionnaire, the patient rates, on a scale of 1 to 9, the provider’s efforts to understand the surgical plan of care from the patient’s perspective. The CollaboRATE SDM tool has demonstrated discriminative validity, concurrent validity, intra-rater reliability, and sensitivity to change.

To access further information, please visit the following websites: [http://www.jmir.org/2014/1/e2/](http://www.jmir.org/2014/1/e2/); [http://www.collaboratescore.org/](http://www.collaboratescore.org/).

**Bariatric Surgery Decision Aid**

Decision aids use a shared, informed approach to clinical decision-making. Potential outcomes of decision aids include increased patient knowledge of available treatments, greater patient participation in decision-making, and improved patient health status and quality of life. Blue Shield of California considers the use of decision aids as a higher level of informed consent and requires patients to acknowledge receipt, review and sign the ECP Bariatric Surgery decision aid as a pre-authorization requirement.

Hospitals and clinicians are encouraged to contribute bariatric surgery data to the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) Qualified Clinical Data Registry.

**Types of Bariatric Surgery Procedures**

The following summarizes the most common bariatric surgery procedures.
Open Gastric Bypass
The original gastric bypass surgeries were based on the observation that postgastrectomy patients tended to lose weight. The current procedure (CPT code 43846) involves both a restrictive and a malabsorptive component, with the 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. The dumping syndrome may further reduce intake, particularly in “sweets eaters.” Surgical complications include leakage and operative margin ulceration at the anastomotic site. Because the normal flow of food is disrupted, there are more metabolic complications than with other gastric restrictive procedures, including iron deficiency anemia, vitamin B12 deficiency, and hypocalcemia, all of which can be corrected by oral supplementation. Another concern is the ability to evaluate the “blind” bypassed portion of the stomach. Gastric bypass may be performed with either an open or laparoscopic technique.

Note: In 2005, CPT code 43846 was revised to indicate that the short limb must be 150 cm or less, compared with the previous 100 cm. This change reflects the common practice in which the alimentary (i.e., jejunal limb) of a gastric bypass has been lengthened to 150 cm. This length also serves to distinguish a standard gastric bypass with a very long, or very, very long gastric bypass, as discussed further here.

Laparoscopic Gastric Bypass
CPT code 43644 was introduced in 2005 and described the same procedure as open gastric bypass (CPT code 43846), but performed laparoscopically.

Mini-Gastric Bypass
Recently, a variant of the gastric bypass, called the mini-gastric bypass (no specific CPT code), has been popularized. Using a laparoscopic approach, the stomach is segmented, similar to a traditional gastric bypass, but instead of creating a Roux-en-Y anastomosis, the jejunum is anastomosed directly to the stomach, similar to a Billroth II procedure. This unique aspect of this procedure is not based on its laparoscopic approach but rather the type of anastomosis used. It should also be noted that CPT code 43846 explicitly describes a Roux-en-Y gastroenterostomy, which is not used in the mini-gastric bypass.

Adjustable Gastric Banding
Adjustable gastric banding (CPT code 43770) involves placing a gastric band around the exterior of the stomach. The band is attached to a reservoir 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. Adjustable gastric banding has been widely used in Europe. Two banding devices are approved by the Food and Drug Administration (FDA) for marketing in the United States. The first to receive FDA approval was the LAP-BAND (original applicant, Allergan, BioEnterics, Carpinteria, CA; now Apollo Endosurgery, Austin, TX). The labeled indications for this device are as follows:

"The LAP-BAND® system is indicated for use in weight reduction for severely obese patients with a body mass index (BMI) of at least 40 or a BMI of at least 35 with one or more severe comorbid conditions, or those who are 100 lb or more over their estimated ideal weight according to the 1983 Metropolitan Life Insurance Tables (use the midpoint for medium frame). It is indicated for use only in severely obese adult patients who have failed more conservative weight-reduction alternatives, such as supervised diet, exercise, and behavior modification programs. Patients who elect to have this surgery must make the commitment to accept significant changes in their eating habits for the rest of their lives."
In 2011, FDA-labeled indications for the LAP-BAND were expanded to include patients with a BMI from 30 to 34 kg/m² with at least 1 obesity-related comorbid condition.

The second adjustable gastric banding device approved by the FDA through the premarket approval process is the REALIZE® model (Ethicon Endo-Surgery, Cincinnati, OH). Labeled indications for this device are:

“[The REALIZE] device is indicated for weight reduction for morbidly obese patients and is indicated for individuals with a Body Mass Index of at least 40 kg/m², or a BMI of at least 35 kg/m² with one or more comorbid conditions. The Band is indicated for use only in morbidly obese adult patients who have failed more conservative weight-reduction alternatives, such as supervised diet, exercise, and behavior modification programs.”

**Sleeve Gastrectomy**

A sleeve gastrectomy (SG; CPT code 43775) is an alternative approach to gastrectomy that can be performed on its own or in combination with malabsorptive procedures (most commonly biliopancreatic diversion [BPD] 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 (overly rapid transport of food through the stomach into intestines) seen with distal gastrectomy. This procedure is relatively simple to perform and can be done as an open or laparoscopic procedure. Some surgeons have proposed the SG as the first in a 2-stage procedure for very high-risk patients. Weight loss following SG may improve a patient’s overall medical status and, thus, reduce the risk of a subsequent more extensive malabsorptive procedure (e.g., BPD).

**Biliopancreatic Diversion**

The BPD procedure (also known as the Scopinaro procedure; CPT code 43847), developed and used extensively in Italy, was designed to address drawbacks of the original intestinal bypass procedures that have been abandoned due to unacceptable metabolic complications. Many complications were thought to be related to bacterial overgrowth and toxin production in the blind, bypassed segment. In contrast, BPD 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. A distal gastrectomy induces temporary early satiety and/or the dumping syndrome in the early postoperative period, both of which limit food intake.

b. A 200-cm long “alimentary tract” consists of 200 cm of ileum connecting the stomach to a common distal segment.

c. A 300- to 400-cm “biliary tract” connects the duodenum, jejunum, and remaining ileum to the common distal segment.

d. 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, creating selective malabsorption. The length of the common segment will influence the degree of malabsorption.

e. Because of the high incidence of cholelithiasis associated with the procedure, patients typically undergo an associated cholecystectomy.

Many potential metabolic complications are related to BPD, including, most prominently, iron deficiency anemia, protein malnutrition, hypocalcemia, and bone demineralization. Protein malnutrition may require treatment with total parenteral nutrition. Also, several case reports have noted liver failure resulting in death or liver transplant.
Biliopancreatic Diversion with Duodenal Switch
CPT code 43845, which specifically identifies the duodenal switch procedure, was introduced in 2005. The duodenal switch procedure is a variant of the BPD previously described. In this procedure, instead of performing a distal gastrectomy, a SG 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 BPD, 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. The SG also decreases the volume of the stomach and decreases the parietal cell mass. However, the basic principle of the procedure is similar to that of the BPD, i.e., producing selective malabsorption by limiting the food digestion and absorption to a short common ileal segment.

Vertical-Banded Gastroplasty
Vertical-banded gastroplasty (CPT code 43842) was formerly one of the most common gastric restrictive procedures performed in the United States but has now been replaced by other restrictive procedures due to high rates of revisions and reoperations. In this procedure, the stomach is segmented along its vertical axis. In order to create a durable reinforced and rate-limiting stoma at the distal end of the pouch, a plug of the 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.

Long-Limb Gastric Bypass (i.e., >150 cm)
Variations of gastric bypass procedures have been described, consisting primarily of long-limb Roux-en-Y procedures (CPT code 43847), which vary in the length of the alimentary and common limbs. For example, the stomach may be divided with a long segment of the jejunum (instead of ileum) anastomosed to the proximal gastric stump, creating the alimentary limb. The remaining pancreaticobiliary limb, consisting of stomach remnant, duodenum, and length of proximal jejunum, is then anastomosed to the ileum, creating a common limb of variable length in which the ingested food mixes with the pancreaticobiliary juices. While the long alimentary limb permits absorption of most nutrients, the short common limb primarily limits absorption of fats. The stomach may be bypassed in a variety of ways (e.g., resection or stapling along the horizontal or vertical axis). Unlike the traditional gastric bypass, which is a gastric restrictive procedure, these very long-limb Roux-en-Y gastric bypasses combine gastric restriction with some element of malabsorptive procedure, depending on the location of the anastomoses. Note that CPT code for gastric bypass (43846) explicitly describes a short limb (<150 cm) Roux-en-Y gastroenterostomy, and thus would not apply to long-limb gastric bypass.

Laparoscopic Malabsorptive Procedure
CPT code 43645 was introduced in 2005, to specifically describe a laparoscopic malabsorptive procedure. However, the code does not specifically describe any specific malabsorptive procedure.

Endoluminal Bariatric Procedures
With endoluminal bariatric (also called endosurgical, endoscopic, or natural orifice) procedures (no specific CPT code), access to the relevant anatomic structures is gained through the mouth without skin incisions. Primary and revision bariatric procedures are being developed to reduce risks associated with open and laparoscopic interventions. Examples of endoluminal bariatric procedures studies include gastroplasty using a transoral endoscopically guided stapler and placement of devices such as a duodenojejunal sleeve and gastric balloon.
Laparoscopic Gastric Plication
Laparoscopic gastric plication (no specific CPT code) is a bariatric surgery procedure that involves laparoscopic placement of sutures over the greater curvature (laparoscopic greater curvature plication) or anterior gastric region (laparoscopic anterior curvature plication) to create a tube-like stomach. The procedure involves 2 main steps—mobilization of the greater curvature of the stomach and suture plication of the stomach for achieving gastric restriction—but technique specifics are not standardized.

Weight Loss Outcomes
There is no uniform standard for reporting results of weight loss or for describing a successful procedure. Common methods of reporting the amount of body weight loss are the percent of ideal body weight achieved or percent of excess body weight (EBW) loss, with the latter most commonly reported. EBW is defined as actual weight minus “ideal weight” and “ideal weight” is based on 1983 Metropolitan Life Insurance height-weight tables for “medium frame.”

These 2 reporting methods are generally preferred over the absolute amount of weight loss because they reflect the ultimate goal of surgery: to reduce weight to a range that minimizes obesity-related morbidity. Obviously, an increasing degree of obesity will require a greater amount of weight loss to achieve these target goals. There are different definitions of successful outcomes, but a successful procedure is often considered one in which at least 50% of EBW is lost, or when the patient returns to within 30% of ideal body weight. The results may also be expressed as the percentage of patients losing at least 50% of EBW. Table 2 summarizes the variations in reporting weight loss outcomes.

Table 2. Weight Loss Outcomes

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Definition</th>
<th>Clinical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in weight</td>
<td>Absolute difference in weight pre- and posttreatment</td>
<td>Unclear relation to outcomes, especially in morbidly obese</td>
</tr>
<tr>
<td>Decrease in BMI</td>
<td>Absolute difference in BMI pre- and posttreatment</td>
<td>May be clinically significant if change in BMI clearly leads to change in risk category</td>
</tr>
<tr>
<td>Percent EBW loss</td>
<td>Amount of weight loss divided by EBW</td>
<td>Has anchor to help frame clinical significance; unclear threshold for clinical significance</td>
</tr>
<tr>
<td>Percent patients losing &gt;50% of EBW</td>
<td>No. patients losing &gt;50% EBW divided by total patients</td>
<td>Additional advantage of framing on per patient basis. Threshold for significance (&gt;50%) arbitrary.</td>
</tr>
<tr>
<td>Percent ideal body weight</td>
<td>Final weight divided by ideal body weight</td>
<td>Has anchor to help frame clinical significance; unclear threshold for clinical significance</td>
</tr>
</tbody>
</table>

BMI: body mass index; EBW: excess body weight.

Durability of Weight Loss
Weight change (i.e., gain or loss) at yearly intervals is often reported. Weight loss at 1 year is considered the minimum length of time for evaluating these procedures; weight loss at 3 to 5 years is considered an intermediate time period for evaluating weight loss; and weight loss at 5 to 10 years or more is considered to represent long-term weight loss following bariatric surgery.

Short-Term Complications (Operative and Perioperative Complications <30 Days)
In general, the incidence of operative and perioperative complications is increased in obese patients, particularly in thromboembolism and wound healing. Other perioperative complications include anastomotic leaks, bleeding, bowel obstruction, and cardiopulmonary complications (e.g., pneumonia, myocardial infarction).

Reoperation Rate
Reoperation may be required to “take down” or revise the original procedure. Reoperation may be particularly common in vertical-banded gastroplasty due to pouch dilation.
**Long-Term Complications (Metabolic Adverse Events, Nutritional Deficiencies)**

Metabolic adverse events are of particular concern in malabsorptive procedures. Other long-term complications include anastomotic ulcers, esophagitis, and procedure-specific complications such as band erosion or migration for gastric banding surgeries.

**Improved Health Outcomes in Terms of Weight-Related Comorbidities**

Aside from psychosocial concerns, which may be considerable, one motivation for bariatric surgery is to decrease the incidence of complications of obesity, such as diabetes, cardiovascular risk factors (i.e., increased cholesterol, hypertension), obstructive sleep apnea, or arthritis. Unfortunately, these final health outcomes are not consistently reported.

**Literature Review**

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens, and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice. The following is a summary of the key literature to date.

**Overview: Bariatric Surgery in Adults with Morbid Obesity**

There is a vast literature on bariatric surgery for adults with morbid obesity. This literature is characterized by a preponderance of single-arm clinical series from individual institutions. These types of studies can be used to determine the amount of weight loss expected from surgery, the durability of the weight loss, and the rate of adverse events. However, these studies are not adequate for determining the comparative efficacy of bariatric surgery vs conservative treatment, or the comparative efficacy of different bariatric surgery techniques. Some comparative trials, including randomized and nonrandomized designs, compare bariatric surgery with conservative therapy and/or compare outcomes of different bariatric surgery procedures. RCTs of bariatric surgery have been performed but are limited and insufficient to draw conclusions about comparisons of bariatric surgery and conservative treatments for weight loss. RCTs are difficult in bariatric surgery because many experts consider it inappropriate or unethical to randomize patients to bariatric surgery. Also, most patients and clinicians have strong preferences for treatment, which result in a select population that might agree to randomization and, therefore, limited generalizability. As a result, the emphasis for this evidence review is on comparative nonrandomized trials of bariatric surgery and nonsurgical therapy or of different types of bariatric surgery procedures.

**Swedish Obese Subjects Trial**

The Swedish Obese Subjects (SOS) trial is the most influential study of bariatric surgery vs conservative treatment. The SOS trial started in 1987 with a registry containing a detailed questionnaire and clinical data on obese patients with a body mass index (BMI) greater than 34 kg/m² at 480 primary health care centers in Sweden. From this registry, patients who met
eligibility criteria were recruited and offered bariatric surgery. Thus, SOS patients self-selected into treatment, and there were baseline differences between groups, primarily reflecting more excess weight and a higher incidence of comorbidities in the surgery group. A total of 2010 people chose surgery, and 2037 people chose conservative care. Each surgical patient was matched on 18 clinical variables with a patient from the registry who received nonsurgical treatment (usual care). Each surgeon chose the surgical procedure offered. Most procedures were vertical-banded gastroplasty (VBG; >70%), with gastric bypass (6%) and gastric banding (23%) procedures performed as well. Usual care in the SOS trial was the local practice of the primary care center and usually did not include pharmacologic treatment. Patients were followed at regular intervals with repeat questionnaires and physical examinations for at least 10 years.

Many publications from this trial have reported on methods, weight loss, and clinical outcomes. The following general conclusions can be drawn from the SOS study:

- Weight loss was greater with bariatric surgery than with conservative treatment. At 10 years of follow-up, weight loss in the surgery group was 16% of total body weight compared with a weight gain of 1.6% in the conservative treatment group.
- There was significant improvement in glucose control for diabetics and reduced incidence of new cases of diabetes.
- The effect on other cardiovascular risk factors (e.g., hypertension, lipidemia) was also positive, but less marked than that seen for diabetes.
- Mortality was reduced by 29% after a mean follow-up of 10.9 years.
- Quality of life improved in the 2- to 10-year follow-up period, with the degree of improvement in quality of life correlating with the amount of weight loss.

**Longitudinal Assessment of Bariatric Surgery Consortium**

The Longitudinal Assessment of Bariatric Surgery Consortium study is a large prospective, longitudinal, noncomparative study of patients who underwent Roux-en-Y gastric bypass (RYGB) or laparoscopic adjustable gastric banding (LAGB) with follow-up through three years postprocedure. The study enrolled 2458 subjects, with median a BMI 45.9 kg/m² (interquartile range [IQR], 41.7-51.5 kg/m²). For their first bariatric surgical procedure, 1738 participants underwent RYGB, 610 LAGB, and 110 other procedures. At 3-year follow-up, for 1533 Roux-en-Y patients with available data, the percentage of baseline weight lost was 31.5% (IQR, 24.6%-38.4%). For the 439 LAGB patients with available data at 3 years, the percentage of baseline weight loss was 15.9% (IQR, 7.9%-23.0%). At 3 years postsurgery, 67.5% and 28.5% of RYGB and LAGB patients, respectively, had at least partial diabetes remission. Dyslipidemia was in remission in 61.9% and 27.1% of RYGB and LAGB patients, respectively. Subsequent bariatric procedures (revision or reversal) were required in 0.3% (95% confidence interval [CI], 0.1% to 0.9%) of the RYGB patients and in 17.5% (95% CI, 13.8% to 21.9%) of LAGB patients.

**Systematic Reviews**

Numerous systematic reviews have compared the efficacy of bariatric surgery with conservative therapy or compared different types of bariatric surgery techniques, some of which are older and do not extend across the full range of available studies. Kang et al (2017) conducted a systematic review with a network meta-analysis that compared the 3 most common types of bariatric surgery techniques: RYGB, sleeve gastrectomy (SG), and LAGB. The literature search, conducted through July 2016, identified 11 RCTs for inclusion (8 RYGB vs SG; 2 RYGB vs LAGB; 1 SG vs LAGB). Quality of the trials was assessed using the Jadad score, based on allocation concealment, blinding, intention-to-treat analysis, power calculation, and funding. Most trials had a Jadad score of 3 (scale range, 1-5). A meta-analysis for the outcome of BMI reduction (6 trials) showed that there was no difference between SG and RYGB (0.7; 95% CI, -1.6 to 3.1). A meta-analysis of RYGB and LAGB (2 trials) and a single trial of SG and LAGB showed that LAGB was not as effective as RYGB or SG (5.8; 95% CI, 2.3 to 9.1; and 5.1; 95% CI, 0.9 to 8.9; respectively). Meta-analyses for the outcome of percent excess weight loss (EWL) showed the same pattern, no difference comparing SG and RYGB (5 trials; -4.0; 95% CI, -14.0 to
8.2), and both SG and RYGB more effective than LAGB (2 trials; 22.0; 95% CI, 6.5 to 34.0; 1 trial; 26.0; 95% CI, 6.4 to 41.0; respectively).

Colquitt et al (2014) updated 2003 and 2009 Cochrane reviews of bariatric surgery for obesity.\(^{13}\) They identified 22 randomized trials that compared bariatric surgery with nonsurgical obesity management or that compared different bariatric surgery procedures (total N=1798 participants; sample size range, 15-250 participants). All 7 RCTs comparing surgery with nonsurgical interventions found benefits of surgery on measures of weight change at 1- to 2-year follow-ups. However, reviewers noted that adverse event rates and reoperation rates were poorly reported across trials, and long-term follow-up (beyond 1-2 years) was limited.

Gloy et al (2013) conducted a systematic review and meta-analysis of RCTs comparing current bariatric surgery techniques with nonsurgical treatment for patients with BMI of 30 kg/m\(^2\) or more.\(^{14}\) Eleven studies (total N=796 patients) were included. Overall, patients after bariatric surgery lost more body weight than patients after nonsurgical treatment (mean difference [MD], -26 kg; 95% CI, -31 to -21 kg; p < 0.001). Remission of type 2 diabetes (T2D) was more likely for bariatric surgery patients than for nonsurgical patients (relative risk of T2D remission, 22.1; 95% CI, 3.2 to 154.3; p < 0.000); similarly, remission of metabolic syndrome was more likely for bariatric surgery patients (relative risk, 2.4; 95% CI, 1.6 to 3.6; p < 0.001). After bariatric surgery, 21 (8%) of 261 patients required reoperations (5/124 after LAGB, 4/69 after RYGB, 1/49 after SG, 1/19 after biliopancreatic diversion [BPD]). Similar to the Colquitt meta-analysis, no studies reported longer term follow-up (>2 years) and heterogeneity between studies were high.

Chang et al (2014) published a systematic review and meta-analysis of RCTs and observational studies to evaluate the effectiveness and risks of bariatric surgery.\(^{15}\) Reviewers included 164 studies (37 RCTs, 127 observational studies), with a total of 161,756 patients. Mean presurgery BMI was 45.62 kg/m\(^2\) and, among the studies that provided information about obesity-related comorbidities, 26% of patients had T2D, 47% had hypertension, 28% had dyslipidemia, 7% had cardiovascular disease, and 25% had obstructive sleep apnea (OSA). Perioperative complications were relatively low, with a perioperative mortality rate in RCTs of 0.08% (95% CI, 0.01% to 0.24%) and in observational studies of 0.22% (95% CI, 0.14% to 0.31%). Complication rates were 17% (95% CI, 11% to 23%) for RCTs and 10% for observational studies (95% CI, 7% to 13%). At 1-year follow-up, mean change in BMI was -13.53 kg/m\(^2\) (95% CI, -15.51 to -11.55 kg/m\(^2\)) in RCTs and -11.79 kg/m\(^2\) (95% CI, -13.89 to -9.69 kg/m\(^2\)) in observational studies. Decreases in BMI were generally sustained over 2 to 4 years of follow-up among studies reporting this outcome.

Many systematic reviews have reported improvements in specific obesity-related comorbidities following bariatric surgery. These reviews have relied primarily on the results of observational studies and included the outcomes of hypertension, T2D, hyperlipidemia, cardiovascular events, quality of life, cancer, knee pain, and liver disease.\(^{16-31}\)

Puzziferri et al (2014) conducted a systematic review of studies of bariatric surgery reporting follow-up beyond 2 years, which included 29 studies (total N=7971 patients).\(^{32}\) At follow-up, which ranged from 2 to 5 years postprocedure, the mean sample size-weighted percentage of EWL was higher for gastric bypass (65.7%) than for gastric banding (45.0%). Reviewers noted that few studies reported sufficient long-term results to minimize bias.

**Section Summary: Bariatric Surgery in Adults with Morbid Obesity**

There is a lack of large-scale RCTs with long-term follow-up comparing bariatric surgery with nonsurgical treatment for the general population of patients with morbid obesity. Evidence from nonrandomized comparative studies and case series and meta-analyses of existing RCTs, has consistently reported that bariatric surgery results in substantially greater weight loss than nonsurgical therapy. Data from the largest comparative study (the SOS study) has reported that bariatric surgery is associated with improvements in mortality, diabetes, cardiovascular risk factors, and quality of life.
Evidence for Specific Types of Bariatric Surgery Procedures

Gastric Bypass

The body of literature on improved weight loss has been instrumental in establishing gastric bypass as the reference procedure to which other procedures are compared. Practice patterns in the United States have indicated surgeons have adopted this approach, with gastric bypass now comprising most of the bariatric procedures performed.

Comparative trials summarized in the 2003 Blue Cross Blue Shield Association Technology Evaluation Center (TEC) Assessment consistently reported favorable outcomes for open gastric bypass compared with VBG, including 2 RCTs. Some nonrandomized trials that compared open gastric bypass with procedures other than VBG were also summarized in the TEC Assessment. While there were fewer trials for these other procedures, comparisons of open gastric bypass to gastric banding, horizontal gastroplasty, and silastic ring gastroplasty all reported that weight loss was superior with open gastric bypass. Metabolic abnormalities were seen more frequently in gastric bypass patients than in those receiving a VBG. Anemia, iron deficiency, vitamin B12 deficiency, and red blood cell folate-deficiency were commonly seen. Marginal ulcerations were also seen in gastric bypasses, particularly in those whose gastric pouches were too large and included acid-secreting parietal cells.

A 2005 TEC Assessment focused on laparoscopic gastric bypass, which intends to reproduce the open procedure via minimally invasive techniques. This technically complex surgery requires a dedicated team and a relatively high degree of skill and experience in laparoscopic technique. This Assessment reviewed 7 comparative trials of the open gastric bypass and laparoscopic gastric bypass, including 3 RCTs. Also, 18 large clinical series of laparoscopic gastric bypass were included. The Assessment concluded that weight loss at 1 year was similar for laparoscopic and open gastric bypass approaches. Longer follow-up periods were less well-reported but appeared to be similar for both approaches. While comparisons of complication rates were less certain, some patterns were evident and consistent across the data examined. The profile of adverse events differed between the 2 approaches, with each having advantages and disadvantages. Laparoscopic gastric bypass offered a less invasive procedure associated with decreased hospital stay and earlier return to usual activities. Mortality might be lower with the laparoscopic approach, although both procedures had mortality rates less than 1%. Postoperative wound infections and incisional hemias were also less frequent with laparoscopic gastric bypass. However, anastomotic problems, gastrointestinal tract bleeding, and bowel obstruction appeared to be higher with the laparoscopic approach, though not markedly higher. Given these data, the overall benefit-risk profile for these 2 approaches appeared to be similar.

Yan et al (2016) published a systematic review of RCTs comparing gastric bypass with medical treatment in obese patients (i.e., BMI ≥30 kg/m²) who had T2D. The primary study outcome was remission of T2D, which was reported in 5 of the 6 studies. A pooled analysis found a significantly higher remission rate after gastric bypass than after medical treatment (odds ratio [OR], 76.37; 95% CI, 20.70 to 271.73; p < 0.001). Also, a pooled analysis found a significantly lower final BMI in the gastric bypass group than in the medical treatment group (MD = -6.54 kg/m²; 95% CI, -9.28 to -3.80 kg/m²; p < 0.001).

Many clinical series reporting results of open gastric bypass have been published, as have numerous systematic reviews of this evidence. Griffen summarized the experience of more than 10,000 gastric bypass operations from a number of bariatric surgeons. Results showed that approximately 85% were able to reduce their weight to levels below 150% of their ideal weight. In about 5000 patients who were followed for 10 years, 80% were maintained this result. Pories et al reported on 608 patients who underwent a gastric bypass procedure and were followed up for 1 to 14 years. One unique feature of this report is that only 3% of patients were lost to follow-up. Average weight loss was 75% of excess weight at 1 year, declining to 50% by the eighth year. The authors observed an immediate drop in both blood glucose and exogenous insulin
requirements after surgery. Long-term observation of 298 patients with preoperative diabetes or impaired glucose intolerance revealed that 91% had normal values for blood glucose and hemoglobin A1c (HbA1c) after surgery. The incidence of hypertension declined from 58% before surgery to 14% after gastric bypass.

The mini-gastric bypass has primarily been advocated by 1 surgeon. In 2001, Rutledge published his experience with 1274 patients who underwent this procedure. Mean operating time was 36 minutes, and mean hospital stay was 1.5 days. Mean EWL was 51% at 6 months, 68% at 12 months, and 77% at 2 years. The overall complication rate reported was 5.2%. While this surgical approach may result in decreased surgical time, the anastomosis creates the risk of biliary reflux gastritis, one of the reasons that this anastomosis has been abandoned, in general, in favor of a Roux-en-Y anastomosis, which diverts the biliary juices away from the stomach.

**Section Summary: Gastric Bypass**

Gastric bypass has been extensively studied. TEC Assessments and other systematic reviews have found that gastric bypass improved health outcomes, including weight loss and remission of T2D. A TEC Assessment also found similar weight loss with open and laparoscopic gastric bypass.

**Laparoscopic Adjustable Gastric Banding**

A 2006 TEC Assessment updated the evidence on LAGB and compared outcomes with gastric bypass. This Assessment concluded that, for patients considering bariatric surgery, there was sufficient evidence to permit an informed choice between gastric bypass and LAGB. An informed patient might reasonably choose open gastric bypass or LAGB as the preferred procedure. Preoperative counseling should include education on the comparative risks and benefits (e.g., extent of weight loss and frequency and timing of potential complications) of the 2 procedures to optimize choice based on preferences and shared decision making.

Weight loss outcomes from the studies reviewed in the Assessment confirmed that weight loss at 1 year was lower for LAGB than for open gastric bypass. The percentage of EWL at 1 year was approximately 40%, compared with 60% or higher for open gastric bypass. At time points beyond 1 year, some comparative studies have reported that the difference in weight loss between LAGB and open gastric bypass narrows, but other studies did not. Weight loss outcomes from the 9 single-arm series with the most complete follow-up did not support the hypothesis that the difference in weight loss shrinks after 1 to 2 years of follow-up. It appears more likely from the current data that attrition bias might have accounted for the diminution of the difference in weight loss over time, particularly when patients with bands removed or deflated were excluded from analysis.

These studies also confirmed that short-term (peroperative) complications are very low with LAGB and lower than with open gastric bypass or LAGB. Death was extremely rare, and serious perioperative complications probably occurred at rates less than 1%.

The reported rates of long-term adverse events vary considerably. In the comparative trials, reoperations were reported in approximately 25% of patients, while, in the single-arm studies, the composite rate for reoperations was approximately 50% lower (11.9%). The rates of other long-term complications were also highly variable; e.g., the range of rates for band slippage was 1% to 36% and the range for port access problems was 2% to 20%. These data on long-term complications remain suboptimal. The reporting of long-term complications in these trials was not systematic or consistent. While impossible to determine the precise rates of long-term complications from these data, it is likely that complications have been underreported in many studies due to incomplete follow-up and lack of systematic surveillance. A recent publication by Ibrahim et al (2017) reviewed 25,042 Medicare beneficiaries who underwent LAGB surgery; 18.5% (n=4636) patients underwent one or more reoperation(s). Reoperation was prompted by the need for band removal (41.8%), band and port replacement (28.6%), and other requirements.
The rates of long-term complications reported in some studies raise concern about the impact of these events on the overall benefit-risk profile for LAGB.

In comparing LAGB with open gastric bypass, there are tradeoffs in terms of risks and benefits. LAGB is a less invasive procedure associated with fewer procedural complications, decreased hospital stay and earlier return to usual activities. However, benefits defined by the amount of weight lost are lower for LAGB. The patterns of long-term complications also differ between the 2 procedures. For LAGB, longer term adverse events related to the presence of a foreign body in the abdomen will occur and will result in reoperations and removal of the band in a minority of patients. Patients who have their bands removed can later be offered an alternative bariatric surgery procedure, such as gastric bypass.

A systematic review by Chakravarty et al (2012) comparing LAGB with other bariatric surgery procedures drew conclusions similar to the TEC Assessment. Reviewers included 5 RCTs. The RCTs found that patients using LAGB lost weight, but less weight than with other procedures (e.g., gastric bypass or SG). However, the short-term complication rate was lower with LAGB, and no difference was found in quality of life after LAGB vs other procedures.

Section Summary: Laparoscopic Adjustable Gastric Banding

Systematic reviews of the literature have concluded that LAGB is a reasonable alternative to gastric bypass. There is less weight loss with LAGB; however, the procedure is associated with fewer serious adverse events.

Sleeve Gastrectomy

Systematic Reviews

Sleeve Gastrectomy (SG) may be performed as a stand-alone procedure or in combination with a malabsorptive procedure, such as the BPD with duodenal switch (BPD-DS). It has also been proposed as the first step in a 2-stage procedure, with gastric bypass or BPD as the second stage.

Osland et al (2017) published a systematic review and meta-analysis of RCTs comparing laparoscopic vertical SG with RYGB (see Table 3). The literature search, conducted from 2000 to November 2015, identified 9 RCTs for inclusion (total N=865 patients). Four trials were included in meta-analyses comparing percent EWL between the 2 groups. Results at both 6- and 12-month follow-ups showed that the procedures are comparable (see Table 4).

A systematic review by Juodeikis and Brimas (2017) summarized evidence on long-term results after SG (see Table 3). Reviewers included an RCT and 19 retrospective studies, with a total of 2713 patients who received SG. Mean preoperative BMI was 46.9 kg/m². Mean duration of follow-up ranged from 5 to 11 years, and mean proportion of patients followed for 5 years was 68.5%. Seventeen studies (n=1501 patients) reported 5-year follow-up data. At 5 years, resolution of T2D, arterial hypertension, dyslipidemia, OSA, gastroesophageal reflux disease (GERD), and degenerative joint diseases also improved in most patients (see Table 4). Two studies reported weight loss after 7 and 8 years; percent EWL rates were 56.6% and 54.8%, respectively.

In a meta-analysis of 21 randomized and nonrandomized studies (total N=18,766 patients) comparing SG with laparoscopic RYG for morbid obesity, Zhang et al (2015) reported no significant difference in percent EWL from 0.5- to 1.5-year follow-ups (see Tables 3 and 4). However, after 1.5 years, RYG was associated with higher percent EWL (2-year MD=5.77; 95% CI, 4.29 to 7.25; p<0.05). Adverse events were more frequent following RYG (OR for major complication, 1.29; 95% CI, 1.22 to 3.22; p<0.01).

Trastulli et al (2013) conducted a systematic review of 15 RCTs (total N=1191 patients) that compared SG with other bariatric procedures (see Table 3). Summary statistics were provided; meta-analyses were not conducted (see Table 4). Reviewers reported mean complication rates...
with SG of 12.1% (range, 10%-13.2%) compared with 20.9% with LAGB (range, 10%-26.4%).
Percent EWL ranged from 49% to 81% with SG and from 62.1% to 94.4% with LAGB.

Brethauer et al (2009) reviewed 36 studies (total N=2570 patients) in a systematic review of SG as a staged and primary procedure, the largest trials coming from European centers (see Table 3).46 Thirteen studies (n=821 patients) reported on high-risk patients having a staged approach and 24 studies (n=1749 patients) on SG as primary procedure. Mean percent EWL, reported in 24 studies (n=1662 patients), was 55.4% overall. Mean postoperative BMI, reported in 26 studies (n=1940 patients), decreased from a baseline of 51.2 to 37.1 kg/m². Other studies reported weight loss in terms of BMI decrease, the percentage of weight lost, or percentage of total weight lost; all had significant reductions from baseline. Rates of major postoperative complications ranged from 0% to 23.8% for all studies and from 0% to 15.3% in studies with more than 100 patients. Leaks (2.2%), bleeding episodes requiring reoperation (1.2%), and postoperative strictures requiring endoscopic or surgical intervention (0.6%) were reported in the 33 studies (n=2570 patients). All extracted studies reported mortality data, with 5 deaths within 30 days of surgery (overall mortality rate, 0.19%; 2 in the high-risk/staged group, 3 in the primary procedure group).

Table 3. Systematic Review Characteristics for Sleeve Gastrectomy

<table>
<thead>
<tr>
<th>Study</th>
<th>Dates</th>
<th>Studies</th>
<th>Participants</th>
<th>Design</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osland et al</td>
<td>through Nov 2017</td>
<td>9</td>
<td>SG=437; RYG =428</td>
<td>RCTs</td>
<td>3 mo to 5 y</td>
</tr>
<tr>
<td>Juodeikis et al</td>
<td>Through May 2016</td>
<td>20</td>
<td>1626</td>
<td>1 RCT, 19 retrospective</td>
<td>5 to 11 y</td>
</tr>
<tr>
<td>Zhang et al</td>
<td>Through Oct 2013</td>
<td>21</td>
<td>18,766</td>
<td>8 RCTs, 13 nonrandomized comparative</td>
<td>1 to 5 y</td>
</tr>
<tr>
<td>Trastulli et al</td>
<td>Through Nov 2012</td>
<td>15</td>
<td>1191</td>
<td>RCTs</td>
<td>6 mo to 3 y</td>
</tr>
<tr>
<td>Brethauer et al</td>
<td>1996 to 2009</td>
<td>36</td>
<td>2570</td>
<td>2 RCTs, 1 cohort, 33 case series</td>
<td>3 mo to 5 y</td>
</tr>
</tbody>
</table>

NR: not reported; RCT: randomized controlled trial; RYGB: Roux-en-Y gastric bypass; SG: sleeve gastrectomy.

Table 4. Systematic Review Results for Sleeve Gastrectomy

<table>
<thead>
<tr>
<th>Study</th>
<th>Percent EWL (95% CI)</th>
<th>Comorbidities (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osland et al</td>
<td>Mean difference, SG and RYG:</td>
<td>Remission/improvement:</td>
</tr>
<tr>
<td></td>
<td>6 mo (3 trials): 0.5 (-5.0 to 6.0)</td>
<td>Type 2 diabetes: 77.8%</td>
</tr>
<tr>
<td></td>
<td>12 mo (2 trials): 7.6 (-0.1 to 15.3)</td>
<td>Hypertension: 68.0%</td>
</tr>
<tr>
<td></td>
<td>5 y (17 trials): 58.4%</td>
<td>Dyslipidemia: 65.9%</td>
</tr>
<tr>
<td></td>
<td>7 y (2 trials): 56.6%</td>
<td>Sleep apnea: 75.8%</td>
</tr>
<tr>
<td></td>
<td>11 y (1 trial): 62.5%</td>
<td></td>
</tr>
<tr>
<td>Juodeikis et al</td>
<td>Mean rates for SG:</td>
<td>Remission/improvement:</td>
</tr>
<tr>
<td>Zhang et al</td>
<td>6 mo (9 studies): 0.2 (-2.5 to 2.9)</td>
<td>Type 2 diabetes: 10 studies: 3.3 (2.0 to 5.5)</td>
</tr>
<tr>
<td></td>
<td>12 mo (15 studies): 2.9 (-0.2 to 6.0)</td>
<td>Hypertension (10 studies): 1.3 (0.7 to 2.4)</td>
</tr>
<tr>
<td></td>
<td>4 y (3 studies): 2.7 (0.2 to 5.2)</td>
<td>Dyslipidemia (5 studies): 1.1 (0.3 to 1.3)</td>
</tr>
<tr>
<td></td>
<td>Mean difference resolution, RYG and SG:</td>
<td>Sleep apnea (7 studies): 1.5 (0.8 to 2.6)</td>
</tr>
<tr>
<td></td>
<td>Type 2 diabetes: 67% to 100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LGB: 62% to 94%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LAGB: 29% to 48%</td>
<td></td>
</tr>
<tr>
<td>Brethauer et al</td>
<td>Mean rate overall for SG:</td>
<td>Remission/improvement:</td>
</tr>
<tr>
<td></td>
<td>55% (range, 33%-85%)</td>
<td>Type 2 diabetes: &gt;70%</td>
</tr>
<tr>
<td></td>
<td>55% (range, 33%-85%)</td>
<td>Significant reductions also seen in hypertension, hyperlipidemia, and sleep apnea</td>
</tr>
</tbody>
</table>
Randomized Controlled Trials
An RCT comparing short-term outcomes of laparoscopic SG with gastric bypass was published in 2012.47 Trialists compared 30-day outcomes for 117 patients randomized to gastric bypass with 121 patients randomized to laparoscopic SG. The rate of major complications (no deaths in either group) was 9.4% in the gastric bypass group compared with 5.8% in the LSG group (p=0.29). Minor complications were more common in the gastric bypass group than in the laparoscopic SG group (17.1% vs 7.4%, p=0.02), as were combined major and minor complications (26.5% vs 13.2%, p=0.01).

Karamanakos et al (2008) carried out a double-blind RCT comparing outcomes of laparoscopic RYGB and laparoscopic SG on body weight, appetite, fasting, and postprandial ghrelin and peptide YY (levels at 1, 3, 6, and 12 months after surgery).48 Thirty-two patients were randomized, half to each procedure. The decrease in body weight and BMI were marked and comparable in each group. EWL was greater after LSG than laparoscopic RYGB at 6 months (55.5% vs 50.2%; p=0.04) and 12 months (69.7% vs 60.5%; p=0.05), all respectively. Fasting peptide YY levels increased after both surgical procedures. Appetite decreased in both groups but decreased more after laparoscopic SG.

Himpens et al (2006) reported on a randomized trial comparing LAGB with laparoscopic isolated SG in 80 patients and reported 3-year follow-up.49 Median baseline BMI was 37 kg/m² (range, 30-47 kg/m²) in the LAGB group and 39 kg/m² (range, 30-53 kg/m²) in the SG group. Outcomes of weight loss, feeling of hunger, sweet-eating, GERD, complications, and reoperations were recorded at 1- and 3-year follow-ups. Median decrease in BMI in the gastric bypass group was 15.5 kg/m² (range, 5-39 kg/m²) after 1 year and 18 kg/m² (range, 0-39 kg/m²) at 3 years after LAGB. One year after SG, decrease in BMI was 25 kg/m² (range, 0-45 kg/m²) and 27.5 kg/m² (range, 0-48 kg/m²) after 3 years. Median EWL in the LAGB group was 41.4% after 1 year and 48% at 3 years. Median EWL after SG was 58% and 66% at 1 and 3 years, respectively. More patients having SG than LAGB reported a loss of craving for sweets, but the difference was not statistically significant; GERD appeared de novo in more SG than LAGB patients at 1 year, and the relation reversed at 3 years; between-group differences were not statistically significant at either time point. Two SG patients required reoperation for complications. Seven late complications required reoperation after LAGB, including pouch dilations treated by band removal (n=2) or conversion to RYGB (n=1), 1 gastric erosion treated by conversion to RYGB, and 3 system disconnections that required reconnection. Four patients had reoperations for lack of efficacy (2 LAGB patients underwent conversion to RYGB, 2 SG patients underwent conversion to duodenal switch). The trialists noted that the number of reoperations was significant in both groups and that the severity of complications was greater in the SG group.

Section Summary: Sleeve Gastrectomy
Systematic reviews of RCTs and observational studies, evaluating SG alone and comparing SG with RYGB, have found that SG results in substantial weight loss, comparable to RYGB and that this weight loss is durable for at least 5 years. A meta-analysis found that short-term weight loss was similar after SG or gastric bypass. Long-term weight loss was greater after gastric bypass, but SG is associated with fewer adverse events.

Biliopancreatic Diversion with Duodenal Switch
BPD may be performed with or without the duodenal switch procedure. In the BPD-DS, an SG is performed, preserving the pyloric sphincter. Preservation of the pyloric sphincter is intended to ameliorate the dumping syndrome and to decrease the incidence of ulcers at the duodenoileal anastomosis by providing a more physiologic transfer of stomach contents to the duodenum.
Systematic Review
In an evidence-based review of literature, Farrell et al (2009) summarized data on BPD with or without duodenal switch, RYGB (proximal), and LAGB, and reported that at a mean 1-year follow-up, EWL for BPD with or without duodenal switch (outcomes with and without duodenal switch not reported separately) was 72% (4 studies; n=896 patients), 67% for RYGB (7 studies; n=1627 patients), and 42% for LAGB (11 studies; n=4456 patients).\(^5\) At mean follow-up of 5 years, EWL for BPD with or without duodenal switch was 73% (3 studies; n=174 patients), 58% for RYGB (3 studies; n=176 patients), and 55% for LAGB (5 studies; n=640 patients). Reviewers noted that “given the marked paucity of prospectively collected comparative data among the different bariatric operations, it remains impossible to make definitive recommendations for one procedure over another.”

Nonrandomized Comparative Studies
Skogar et al (2017) published results from a retrospective mail survey of patients undergoing BPD-DS (n=113) or RYGB (n=98) (see Table 5).\(^6\) Reduction in BMI was statistically larger in patients receiving BPD-DS compared with patients receiving RYGB (see Table 6). Both groups experienced significant reductions in diabetes and OSA. Significant reductions in dyslipidemia were only seen in the group receiving BPD-DS. The overall complication rate was lower for patients undergoing RYGB.

Strain et al (2007) published a comparative study of 72 patients who underwent RYGB (n=50) or BPD (n=22) (see Table 5).\(^7\) Choice of surgery was by the surgeon and/or patient, and the patient populations differed by age and time since surgery. Weight loss at 1 year was greater for BPD, with a reduction in BMI of 10.6 kg/m\(^2\) (23.3 lb) for BPD compared with 7.5 kg/m\(^2\) (16.5 lb) for RYGB (p<0.001).

Prachand et al (2006) published the largest comparative study of 350 super-obese patients with BMI greater than 22.7 kg (50 lb) who underwent RYGB (n=152) or Scopinaro BPD combined with the DeMeester BPD-DS (n=198) (see Table 5).\(^8\) In this retrospective study, the decision for surgery was made by the surgeon and/or patient. The BPD-DS patients differed from RYGB patients on baseline weight and BMI; mean weight was 167 kg (368 lb; range, 267-597 lb) in BPD-DS patients and 157 kg (346 lb; range, 240-505 lb) in the RYGB group, and mean BMI was 27 kg/m\(^2\) (59 lb; range, 50-96 lb) in BPD-DS patients vs 26 kg/m\(^2\) (56 lb; range, 50 to 84 lb) in the RYGB group. At 1 year, data were reported for 143 BPD-DS patients and 81 RYGB patients (see Table 6). EWL was greater for BPD (64.1%) vs RYGB (55.9% p<0.01), and the reduction in BMI was also greater with BPD (10.7 kg/m\(^2\) [23.6 lb]) vs RYGB (8.8 kg/m\(^2\) [19.4 lb]; p<0.001). Complications and data on the resolution of comorbidities were not reported.

Table 5. Nonrandomized Comparative Study Characteristics for BPD-DS

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Dates</th>
<th>Participants</th>
<th>Follow-Up</th>
</tr>
</thead>
</table>


Table 6. Nonrandomized Comparative Study Results for BPD-DS

<table>
<thead>
<tr>
<th>Study</th>
<th>Mean Reduction in BMI (SD)</th>
<th>Percent Achieving ≥50% EWL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Presurgery, kg/m(^2)</td>
<td>Post surgery, kg/m(^2)</td>
</tr>
<tr>
<td>Skogar et al (2017)(^5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BPD-DS</td>
<td>56 (6.7)</td>
<td>31 (5.5)</td>
</tr>
<tr>
<td>RYGB</td>
<td>52 (4.0)</td>
<td>36 (7.1)</td>
</tr>
<tr>
<td>Strain et al (2007)(^5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BPD-DS</td>
<td>54 (11.9)</td>
<td>30 (6.1)</td>
</tr>
<tr>
<td>RYGB</td>
<td>48 (6.3)</td>
<td>31 (5.0)</td>
</tr>
</tbody>
</table>
### Study Means Reduction in BMI (SD) Percent Achieving ≥50% EWL

<table>
<thead>
<tr>
<th>Study</th>
<th>Mean Reduction in BMI</th>
<th>Percent Achieving ≥50% EWL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prachand et al (2006)</td>
<td>59 (6.7)</td>
<td>27.8</td>
</tr>
<tr>
<td>BPD-DS</td>
<td>56 (6.8)</td>
<td>18.9</td>
</tr>
</tbody>
</table>

BM: body mass index; BPD-DS: biliopancreatic diversion with duodenal switch; EWL: excess weight loss; RYGB: Roux-en-Y gastric bypass.

* Between groups, difference in change
* p < 0.05.

### Case Series

Strain et al (2017) reported on the nutrient status of 190 patients receiving BPD-DS after 9 years of follow-up. At baseline, the patients had a mean age of 43 years and mean BMI of 53 kg/m². All patients reported taking some supplements. Deficiencies in protein, iron, and calcium developed by year 3 and continued through the study. Zinc deficiencies developed by year 5. Folate levels increased during the study, probably due to the efficacy of the supplement. The authors warned that interventions need to be implemented to improve nutrient status in patients receiving BPD-DS.

The largest case series of this procedure is by Marceau et al (2009), who reported on their 15-year experience with duodenal switch in 1423 patients from 1992 to 2005. Follow-up evaluations were available for 97% of patients. Survival rate was 92%. After a mean of 7 years (range, 2-15 years), 92% of patients with an initial BMI of 50 kg/m² or less obtained a BMI of 35 kg/m² or less, and 83% of patients with BMI greater than 50 kg/m² achieved a BMI of less than 40 kg/m². Diabetes medication was discontinued in 92% and decreased in others. Use of continuous positive airway pressure was discontinued in 92% of patients, and the prevalence of cardiac risk index greater than 5 decreased by 86%. Operative mortality was 1%, the revision rate was 0.7%, and the reversal rate was 0.2%. Revision for failure to lose sufficient weight was needed in only 1.5% of patients. Severe anemia, vitamin deficiency, or bone damage were preventable or easily treated and without documented permanent damage.

### Section Summary: Biliopancreatic Diversion with Duodenal Switch

Nonrandomized comparative studies have found significantly higher weight loss after BPD-DS compared with gastric bypass at 1 year. A large case series found sustained weight loss after 7 years.

### Biliopancreatic Diversion without Duodenal Switch

The available evidence on BPD-DS was reviewed in the 2006 TEC Assessment, and BPD outcomes, with or without DS, were compared with those of gastric bypass. One comparative trial and 7 single-arm series suggested that weight loss outcomes at 1 year were in the same range as for gastric bypass. While these data were not sufficient to distinguish small differences in weight loss between the 2 procedures, they did not support the hypothesis that BPD resulted in greater weight loss than open gastric bypass.

Complication rates have been poorly reported in these trials. The data have suggested that mortality is low (≤1%) and in the same range as for open gastric bypass. However, rates of other complications, especially long-term complications, cannot be determined from these data. Limited data have suggested that long-term nutritional and vitamin deficiencies occur at a high rate following BPD. Slater et al (2004) focused specifically on vitamin and calcium deficiencies following BPD. They reported high rates of vitamin and calcium abnormalities in their population over a 4-year period. By year 4, 48% of patients had low calcium, and 63% had low levels of vitamin D. Other fat-soluble vitamins showed similar patterns of abnormalities. Low vitamin A was found in 69% of patients at 4 years, low vitamin K in 68%, and low zinc in 50%. Dolan et al (2004) reported similar data in a study that compared several technical variations of BPD. They reported low calcium levels in 12% to 34% of patients, low vitamin D in 22.2% to 70.6%,
low vitamin A in 53% to 67%, and low vitamin K in 44% to 59%. Also, this study reported high rates of iron deficiency (11%-47%) and anemia (11%-40%).

Skroubis et al (2006) randomized 130 patients with a BMI of 35 to 50 kg/m² to RYGB or BPD without duodenal switch using a variant of BPD that included Roux-en-Y gastrectomy in place of SG.58 All patients were followed for at least 2 years. Weight loss outcomes were superior for the BPD group at every interval examined up to 2 years. EWL at 1 year was 73.7% for RYGB and 83.1% for BPD (p < 0.001); at 3 years, EWL was 72.6% for RYGB and 83.1% for BPD (p < 0.001). There were more early complications in the RYGB group, but this difference was not statistically significant (6 complications vs 1, respectively; p = 0.12). Late complications also did not differ significantly between the RYGB group (16 complications) and BPD groups (22 complications; p = 0.46).

Numerous clinical series of BPD have been published but high-quality trials directly comparing outcomes of this procedure with gastric bypass are lacking. The largest experience with BPD (total N = 1217 patients) was reported by Scopinaro et al (1996), who developed the procedure.59 With a follow-up of up to 9 years, the authors reported a durable EWL of 75%, suggesting that weight loss is greater with this procedure than with gastric restrictive procedures. Also, most patients reported disappearance or improvement of complications such as OSA, hypertension, hypercholesteremia, and diabetes. The authors considered protein malnutrition the most serious metabolic complication, occurring in almost 12% of patients and responsible for 3 deaths. This complication could require inpatient treatment with total parenteral nutrition. To address protein malnutrition, 4% of patients underwent reoperation to elongate the common limb (thus increasing protein absorption) or to have the operation reversed, restoring normal intestinal continuity. The authors also found that protein malnutrition was strongly related to ethnicity and, presumably, patient eating habits, with an increased incidence among those from southern Italy where the diet contains more starch and carbohydrates than the north. Peripheral neuropathy may occur in the early postoperative period due to excessive food limitation but may be effectively treated with large doses of thiamine. Bone demineralization, due to decreased calcium absorption, was seen in about 33% of patients during the first 4 postoperative years. All patients were encouraged to maintain an oral calcium intake of 2 g/d, with monthly vitamin D supplementation.

Section Summary: BPD Without Duodenal Switch
A TEC Assessment reviewed the available observational studies and concluded that weight loss was similar after BPD without the duodenal switch and gastric bypass. However, BPD without duodenal switch leads to complications, especially long-term nutritional and vitamin deficiencies.

Vertical-Banded Gastroplasty
Vertical-banded gastroplasty (VBG) is a purely restrictive procedure that has been replaced by LAGB or 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%.60,61

Systematic Reviews
Hseih et al (2014) conducted a systematic review of studies reporting greater than 10-year follow-up for VBG, which included 3 studies with extractable data.62 Mean EWL was 61.4% from baseline to follow-up in the 3 studies, but reviewers noted a lack of long-term evidence related to outcomes following VBG.

A number of nonrandomized, comparative studies of open gastric bypass vs VBG were included in the 2003 TEC Assessment (N = 8 studies, total N = 3470 patients).33 All 8 studies reported greater amounts of weight loss with open gastric bypass. These studies reported a 44% to 70% improvement in total weight loss, a 28% to 43% improvement in the percent EWL, and 19% to 36%
more patients with more than 50% EWL for those undergoing gastric bypass compared with VBG. Comparison of adverse events was difficult because the data did not permit rigorous assessment. Nevertheless, the data suggested that the mortality rate for both surgeries was low overall. Serious perioperative adverse events were also infrequently reported, but somewhat higher for gastric bypass. Long-term adverse events were inconsistently reported, although it appeared that revision rates were higher for VBG.

**Randomized Controlled Trials**
A small body of literature has compared outcomes between VBG and open gastric bypass. The most rigorous of these comparative trials, the Adelaide Study (1990), randomized 310 morbidly obese patients to gastric bypass, VBG, or horizontal gastroplasty. The percentage of patients with greater than 50% EWL at 3-year follow-up was 67% for gastric bypass, 48% for VBG, and 17% for horizontal gastroplasty (p<0.001). There were no demonstrable differences in adverse events across groups.

A second, smaller RCT by Sugerman et al (1987) randomized 40 patients to a VBG or a gastric bypass procedure. After 9 months, the gastric bypass patients had significantly greater weight loss that was maintained at 3-year follow-up. The gastric bypass patients lost approximately 64% of excess weight, whereas the gastroplasty patients lost 37% of excess weight.

**Case Series**
Relatively high rates of complications, revisions, and reoperations led to the abandonment of VBG as a bariatric surgery procedure in the United States. An example of these results is a large case series with long-term follow-up by MacLean et al (1990), who reported on 201 patients undergoing VBG followed for a minimum of 2 years. Staple line perforation occurred in 48% of patients, and 36% underwent reoperation either to repair the perforation or to repair a stenosis at the rate-limiting orifice. However, the more than 50% of patients who maintained an intact staple line had a durable weight loss of 75% to 100% of excess weight.

**Section Summary: Vertical-Banded Gastroplasty**
A TEC Assessment identified 8 nonrandomized comparative studies evaluating VBG with gastric bypass. The Assessment found that weight loss was significantly greater with open gastric bypass than with VBG. Also, VBG has relatively high rates of complications, revisions, and reoperations.

**Two-Stage Bariatric Surgery Procedures**
Bariatric surgeries performed in 2 stages have been proposed as a treatment option, particularly for patients with “super-obesity” defined as a BMI greater than 50 kg/m². The rationale for a 2-stage procedure is that the risk of an extensive surgery is prohibitive in patients who are extremely obese. Therefore, a procedure with low risk (usually an SG) is performed first. After the patient loses some weight, thus lowering the surgical risk, a second more extensive procedure (e.g., BPD) is performed.

**Randomized Controlled Trial**
Coffin et al (2017) published results on the use of intragastric balloon (IGB) prior to a laparoscopic gastric bypass in patients with super-obesity. Patients with BMI greater than 45 kg/m² were randomized to an IGB (n=55) or standard medical care (n=60) during the 6 months prior to a planned laparoscopic gastric bypass procedure. Five patients had the IGB removed earlier than 6 months due to complications (n=3) or patient request (n=2). Patients receiving IGBs during the first 6 months of the study experienced significantly more BMI reduction (2.8 kg/m²; range 1.7-6.2 kg/m²) than patients receiving standard care (0.4 kg/m²; range 0.3-2.2 kg/m²). Weight loss during months 6 through 12, after the laparoscopic gastric bypass procedure, was greater in the patients who received standard of care before the procedure. Duration of hospitalization after laparoscopic gastric bypass and quality of life did not differ between groups.
Case Series
Most of the evidence on 2-stage procedures consists of case series of patients undergoing SG as the initial procedure. Many do not report on the second-stage surgery. A minority of patients undergoing first-stage surgery proceed to second-stage surgery. Cottam et al (2006) reported on 126 patients with a mean BMI of 65 kg/m² who underwent LSG as the first phase of a planned 2-stage procedure. The incidence of major perioperative complications for LSG was 13%. After 1 year mean EWL was 46%. Thirty-six (29%) patients proceeded to the second-stage procedure, which was laparoscopic gastric bypass. The incidence of major complications following the second procedure was 8%.

In a similar study, Alexandrou et al (2012) reported on 41 patients who underwent SG as the first-stage of a planned 2-stage procedure. After 1-year follow-up, 12 (29%) patients achieved a BMI of less than 35 kg/m² and were ineligible for the second-stage procedure. Of the remaining 28 patients, 10 (24%) underwent the second-stage procedure. The remaining 18 (44%) patients were eligible for but had not undergone, the second-stage procedure at the last follow-up.

Patients who undergo 2-stage procedures are at risk for complications from both procedures. Silecchia et al (2009) described the complication rates in 87 patients who underwent a stage 1 SG followed by BPD in 27 patients. For the first stage, 16.5% of patients had complications of bleeding, fistula, pulmonary embolism, acute renal failure, and abdominal abscess. For the 27 patients who underwent the second-stage BPD, 29.6% had major complications, including bleeding, duodenoileal stenosis, and rhabdomyolysis.

Section Summary: Two-Stage Bariatric Surgery Procedures
The evidence from an RCT and several case series does not support a 2-stage bariatric surgery procedure for improving outcomes in patients with extreme levels of obesity. There is no evidence to suggest that weight loss is improved or that complications are reduced by this approach. Most patients who receive SG as the initial procedure lose sufficient weight during the first year so that a second procedure is no longer indicated. Also, patients undergoing a 2-stage procedure are at risk for complications from both procedures; therefore, it is likely that overall complications are increased by this approach.

Laparoscopic Gastric Plication
Laparoscopic gastric plication is a bariatric procedure that involves laparoscopic placement of sutures over the greater curvature (laparoscopic greater curvature plication) or anterior gastric region (laparoscopic anterior curvature plication) to create a tube-like stomach. The procedure requires 2 main steps—mobilization of the greater curvature of the stomach and suture plication of the stomach for achieving gastric restriction—but specific techniques are not standardized.

Systematic Reviews
Ji et al (2014) reported on a systematic review of 14 studies reporting outcomes after laparoscopic gastric plication (see Table 7). Reviewers included a nonrandomized matched cohort analysis, 10 uncontrolled case series, and 3 case reports. The nonrandomized cohort study was small (N=19). Talebpour et al (2012) conducted the largest study and had the longest follow-up (800 patients; 12 years), at a single institution where the technique was developed. Only 3 studies identified included more than 100 patients. Mean preoperative BMI ranged from 31.2 to 44.5 kg/m². Mean percent EWL after the procedure was reported in 9 studies (n=1407 patients), and ranged from 31.8% to 74.4% at follow-up times ranging from 6 to 24 months (see Table 8). One study reported weight loss in terms of percent decrease in BMI, with a reported decrease at 6 and 12 months of 66.4% and 60.2%, respectively. One study compared anterior plication with greater curvature plication and reported increased weight loss with greater curvature plication (percent EWL, 53.7% vs 23.3%, respectively). Reporting of complications was heterogeneous across studies, but no deaths were reported, and the rate of major postoperative complications requiring reoperation ranged from 0% to 15.4% (average, 3.7%), most commonly due to gastric obstruction or gastric preformation. Surgical techniques were not standardized.
In a systematic review, Abdelbaki et al (2012) summarized outcomes from 7 studies of laparoscopic gastric plication, two of which enrolled more than 100 patients (total N=307 patients) (see Table 7). Results are summarized in Table 8. All studies reported some incidence of nausea and vomiting, most of which were mild. Twenty (6.5%) patients were readmitted, of whom 14 (4.6%) patients required reoperation, most commonly for gastric obstruction (8/14 [57%]).

### Table 7. Systematic Review Characteristics for Laparoscopic Gastric Plication

<table>
<thead>
<tr>
<th>Study</th>
<th>Dates</th>
<th>Studies</th>
<th>Participants</th>
<th>Design</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ji et al (2014)</td>
<td>Jun 2013</td>
<td>14</td>
<td>1450</td>
<td>1 matched cohort</td>
<td>6 mo to 10 y</td>
</tr>
<tr>
<td>Abdelbaki et al (2012)</td>
<td>NR</td>
<td>7</td>
<td>307</td>
<td>5 case series, 2 case reports</td>
<td>3 y</td>
</tr>
</tbody>
</table>

NR: not reported.

### Table 8. Systematic Review Results for Laparoscopic Gastric Plication

<table>
<thead>
<tr>
<th>Study</th>
<th>% Excessive Weight Loss</th>
<th>Complication Rate (Range), %</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ji et al (2014)</td>
<td>31.8-74.4</td>
<td>3.7 (0-15.4)</td>
<td>Favorable short-term efficacy and safety profile; long-term follow-up and prospective trials needed</td>
</tr>
<tr>
<td>Abdelbaki et al (2012)</td>
<td>6 mo: 51-54, 12 mo: 53-67</td>
<td>8 (7-15.3)</td>
<td>Prospective randomized trials vs established bariatric procedures needed</td>
</tr>
</tbody>
</table>

### Randomized Controlled Trials

Sullivan et al (2017) published results from the ESSENTIAL, a randomized sham-controlled trial evaluating the efficacy and safety of endoscopic gastric plication (see Table 9). Patients (N=332) were randomized 2:1 to the active or sham procedure. All patients were provided low-intensity lifestyle therapy. The primary end point was total body weight loss (TBWL) at 12-month follow-up. The mean difference in TBWL for patients receiving the procedure compared with patients receiving the sham procedure was 3.6% (95% CI, 2.1% to 5.1%). Significant differences between the active and sham groups were also reported in a change in weight from baseline, percent excess weight loss, BMI, and improvement in diabetes (see Table 10). No significant differences were detected in improvements in hyperlipidemia or hypertension between the treatment groups.

Talebpour et al (2017) randomized patients to laparoscopic gastric plication (n=35) or laparoscopic SG (n=35) (see Table 9). Patients were followed for 2 years. Both procedures were equally effective based on weight reduction outcomes (see Table 10). Adverse events (e.g., nausea, hair loss, vitamin D deficiency, iron deficiency) were similar between groups. One death due to pulmonary thromboembolism occurred in the gastric plication group.

### Table 9. RCT Characteristics for Laparoscopic Gastric Plication

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Participants</th>
<th>Interventions</th>
<th>Comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sullivan et al (2017)</td>
<td>U.S.</td>
<td>11</td>
<td>2013-2014</td>
<td>Patients 22-60 y, BMI ≥30 kg/m² and ≥1 obesity-related comorbidity or BMI ≥35 kg/m² and with or without obesity-related comorbidity</td>
<td>Endoscopic gastric plication (n=221)</td>
<td>Sham procedure (n=111)</td>
</tr>
<tr>
<td>Talebpour et al (2017)</td>
<td>Iran</td>
<td>1</td>
<td>2012-2015</td>
<td>Patients with BMI ≥35 kg/m² and ≥1 obesity-related comorbidity or BMI ≥40</td>
<td>Laparoscopic gastric plication</td>
<td>Laparoscopic sleeve gastrectomy</td>
</tr>
</tbody>
</table>
Table 10. RCT Results for Laparoscopic Gastric Plication

<table>
<thead>
<tr>
<th>Study, Trial Name</th>
<th>BMI Reduction</th>
<th>Weight Lossa</th>
<th>Mean Change (SD)b</th>
<th>Difference (95% CI)</th>
<th>Mean (SD)c</th>
<th>Difference (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sullivan et al (2017),73 ESSENTIAL</td>
<td>1.2 (0.6 to 1.9)</td>
<td>3.6 (2.1 to 5.1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscopic gastric plication</td>
<td>1.7</td>
<td>4.9 (7.0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sham</td>
<td></td>
<td>1.4 (5.6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talebpour et al (2017)74</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laparoscopic gastric plication</td>
<td>30.1 (2.8)</td>
<td>72.9 (12.6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laparoscopic sleeve gastrectomy</td>
<td>30.5 (4.3)</td>
<td>72.3 (11.9)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BMI: body mass index; CI: confidence interval.

a For Sullivan et al, percent total body weight loss at 12 months; for Talebpour et al, percent excess weight loss.

b At 12-month follow-up.

c At 24-month follow-up.

Observational Study

Pattanshetti et al (2013) published results of a study that described the evolution of an LAGB plication procedure, a hybrid procedure involving both LAGB and greater curvature plication developed by the authors.75 Eighty patients were included, with a baseline mean BMI of 38.05 kg/m². At 6, 12, 18, and 24 months postsurgery, mean percent EWL was 42.6%, 56.4%, 57.6%, and 65.8%, respectively. Five postoperative complications required reoperation.

Section Summary: Laparoscopic Gastric Plication

There is a shortage of comparative studies, especially RCTs, comparing the safety and efficacy of laparoscopic gastric plication with other bariatric surgery procedures. A 2014 systematic review identified only a single small comparative study, which was not randomized. Since the systematic review, 2 RCTs were published. One RCT compared endoscopic gastric plication with a sham procedure, reporting 1-year follow-up results in favor of the intervention. A second RCT compared laparoscopic gastric plication with sleeve gastrectomy, showing that the 2 procedures had similar outcomes after 2 years of follow-up. Longer term follow-up and additional comparative studies are needed.

Single Anastomosis Duodenoileal Bypass with Sleeve Gastrectomy

No controlled trials of single anastomosis duodenoileal bypass with SG (SADI-S) were identified. Some case series have reported on weight loss and other clinical outcomes up to 5 years postsurgery. One larger series, by Sanchez-Pernaute et al (2015), reported on 97 patients with obesity and T2D.76 The authors reported that control of diabetes, defined as a hemoglobin A₁c (HbA₁c) levels less than 6.0%, was achieved by between 70% and 84% of patients at different time points. Remission rates were higher for patients on oral therapy than those on insulin and were higher in patients with a shorter duration of diabetes.

Observational Studies

Torres et al (2017) published a retrospective chart review of patients from their center receiving bariatric procedures, evaluating outcomes at 3-year follow-up.72 Outcomes were evaluated separately for patients with and without diabetes. For patients without diabetes, comparisons were made among patients who underwent RYGB (n=149) or SADI-S (n=106). For patients with diabetes, comparisons were made among patients who underwent RYGB (n=97), BPD-DS (n=77), or SADI-S (n=97). Among the patients without diabetes, significant differences favoring SADI-S...
over RYGB were found in: percent EWL; systolic blood pressure; total, high-density lipoprotein and low-density lipoprotein cholesterol; and insulin. Significant differences were not found in diastolic blood pressure or fasting glucose. Among the patients with T2D, remission rates using American Diabetic Association criteria were: 55%, 70%, and 76% for patients receiving RYGB, BPD-DS, and SADI-S, respectively. Patients with diabetes who underwent BPD-DS or SADI-S achieved significantly lower total cholesterol and triglyceride levels compared with those undergoing RYGB after 3 years of follow-up.

**Section Summary: Single Anastomosis Duodenoileal Bypass with Sleeve Gastrectomy**

No published controlled trials have evaluated SADI-S. There are a few case series, the largest of which had fewer than 100 patients. A comparative chart review found that patients without diabetes experienced significantly better weight loss and lipid profiles with SADI-S than with RYGB and patients who had diabetes experienced significantly higher rates of remission with SADI-S than with RYGB. Additional studies are needed.

**Duodenojejunal Sleeve**

The EndoBarrier (GI Dynamics) is a fluoropolymer sleeve that is reversibly fixated to the duodenal bulb and extends 80 cm into the small bowel, usually terminating in the proximal jejunum. A systematic review of the effect of EndoBarrier on weight loss and diabetes control outcomes was published in 2016. It included 5 small RCTs (total N=235 patients; range, 18-77 patients), with follow-up ranging from 12 to 24 weeks. Comparators were diet and/or other lifestyle modifications, and 2 studies had sham controls. All studies were judged to be at high-risk of bias using the Cochrane risk of bias tool. Combined results demonstrated that the EndoBarrier group had 12.6% greater EWL (95% CI, 9.0% to 16.2%) than medical therapy. For diabetes control outcomes, trends toward greater improvement in the EndoBarrier group were not statistically significant. Mean difference in hemoglobin A1c (HbA1c) level was -0.8% (95% CI, -1.8% to 0.3%) and the relative risk of reducing or discontinuing diabetic medications was 3.28 (95% CI, 0.54 to 10.73).

The largest single trial was a multicenter RCT published in 2014; it included 77 patients with T2D and a BMI greater than 30 kg/m². Patients were treated for 6 months with EndoBarrier or medical therapy. At 6 months, the EndoBarrier was removed, and patients were followed for an additional 6 months. Thirty-eight patients were randomized to the EndoBarrier group, and 31 (82%) of 38 completed 12 months of treatment. Thirty-nine patients were randomized to medical treatment, and 35 (90%) of 39 completed 12 months of treatment. At 6 months, the decrease in BMI was significantly greater in the EndoBarrier group than in the medical therapy group (3.3 kg/m² vs 1.8 kg/m², p<0.05), and at 12 months the difference in BMI was of marginal statistical significance (2.2 kg/m² vs 1.3 kg/m², p=0.06), respectively. HbA1c level was significantly lower in the EndoBarrier group at 6 months (7.0% vs 7.9%, p<0.05), but at 12 months the difference between groups did not differ significantly (7.3% vs 8.0%, p=0.95).

**Section Summary: Duodenojejunal Sleeve**

A systematic review of evidence on a duodenojejunal sleeve included 5 RCTs and found significantly greater short-term weight loss (12-24 weeks) with duodenojejunal sleeves compared with medical therapy. There was no significant difference in symptom reduction associated with diabetes. However, all RCTs had small sample sizes and were judged by the systematic reviewers to be at high-risk of bias.

**Intragastric Balloon Devices**

Intragastric balloon (IGB) devices are placed in the stomach using an endoscope or swallowing to act as a space-occupying device to induce satiety. As of 2017, 3 gastric balloon devices have FDA approval, all designed to stay in the stomach for no more than 6 months. The ReShape Duo is a saline-inflated dual-balloon system, Obalon is a swallowable 3-balloon system, and the OBERA Intragastric Balloon System (previously marketed outside of the United States as BioEnterics) is a saline-inflated silicone balloon.
Systematic Reviews
Several systematic reviews of RCTs evaluating IGB devices for the treatment of obesity have been published; none was limited to FDA-approved devices.80-82

The systematic review by Tate et al (2017) focused on recent RCTs, published between 2006 and 2016.83 Additional inclusion criteria were: sham, lifestyle modification, or pharmacologic agent as a comparator; at least 1 outcome of body weight change; and study duration of 3 or more months. Eight RCTs were included in the review, with four contributing to the meta-analysis. The meta-analysis included 777 patients and showed a significant improvement in percent TBWL with IGB compared with control (5.5%; 95% CI, 4.3% to 6.8%). However, there was significant heterogeneity among the trials (I²=62%), so interpretation of results is limited. The percent TBWL with IGB is lower than expected with RYGB (reported 27%) or with the most efficacious pharmacologic agent (reported 9%).

Saber et al (2017) identified 20 RCTs reporting weight loss outcomes after IGB implantation or a non-IGB control intervention.80 IGB was compared with sham in 15 trials, behavioral modification in 4 trials, and pharmacotherapy in 1 trial. In 17 trials, patients received lifestyle therapy in addition to other interventions. Studies were published between 1987 and 2015 and sample sizes varied from 21 to 326 participants. Outcomes were reported between 3 and 6 months. In a meta-analysis of 7 RCTs reporting BMI loss as an outcome, there was a significantly greater BMI loss in the IGB group than in the control group (mean effect size [ES], 1.59 kg/m²; 95% CI, -0.84 to 4.03 kg/m²; p<0.001). Findings on other outcomes were similar. A meta-analysis of 4 studies reporting percent EWL favored the IGB group (ES=14.25%; 95% CI, 2.09% to 26.4%; p=0.02). Also, a meta-analysis of 6 studies reporting absolute weight loss favored the IGB group (ES=4.6 kg; 95% CI, 1.6 to 7.6 kg; p=0.003).

Although the review was not limited to FDA-approved devices, older devices were air-filled and newer devices, including the two approved by FDA in 2015, are fluid-filled. Sufficient data were available to conduct a sensitivity analysis of 3-month efficacy data. A meta-analysis of 4 studies did not find a significant difference in weight loss with air-filled IGB devices or a control intervention at 3 months (ES=0.26; 95% CI, -0.12 to 0.64; p=0.19). In contrast, a meta-analysis of 8 studies of fluid-filled devices found significantly better outcomes with the IGB than with control (ES=0.25; 95% CI, 0.05 to 045; p=0.02).

Randomized Controlled Trials
Pivotal trials on both FDA-approved devices have been published. Ponce et al (2015) published a multicenter sham-controlled double-blinded trial evaluating the ReShape Duo IGB.84 A total of 326 patients were randomized to 6 months of treatment with an IGB plus lifestyle therapy (n=187) or a sham device plus lifestyle therapy (n=126). Patients in the control group were given the option of active IGB treatment at 6 months. Key eligibility criteria were age 21 to 60 years, baseline BMI between 30 and 40 kg/m², one or more obesity-related comorbidities, and failure to lose sufficient weight in the past 36 months in a medically supervised weight loss program. A total of 176 IGB and 126 control patients (90% of the randomized population) completed the initial 6-month treatment and were included in the primary end point analysis. After 6 months, 77 patients in the control group opted to receive an IGB; these patients were also included in the IGB safety analysis.

Coprimary effectiveness outcomes, assessed at 6 months, were mean percent EWL and having at least 35% of patients in the IGB group achieving at least a 25% EWL. Both primary effectiveness outcomes were met. In the intention-to-treat analysis, the mean percent EWL at 6 months was 25.1% in the IGB group and 11.3% in the control group (p=0.004). The proportion of patients who achieved at least a 25% EWL was 48.8% with a lower confidence bound of 41.6%. Most adverse events were anticipated accommodative symptoms (e.g., nausea, vomiting, abdominal pain), which generally resolved after 3 to 7 days; they were severe in 1% to 2% of patients and were successfully treated. Most device-related serious adverse events (75% [21/28])
were emergency department visits for treatment of accommodate symptoms. There were no deaths, intestinal obstructions, gastric perforations, or device migrations.

Courcoulas et al (2017) published a multicenter, pivotal RCT evaluating the Obera IGB in the United States (as noted, the device has been used in other countries). A total of 317 patients were randomized and initiated 6 months of treatment with an IGB plus lifestyle therapy (n=137) or lifestyle therapy only (n=136). Patients were followed for an additional 6 months. Key eligibility criteria were age 18 to 65 years, baseline BMI between 30 and 40 kg/m², a history of obesity for at least 2 years, and having failed previous weight loss attempts. Nineteen patients in the IGB group and 121 in the control group completed the 6-month treatment period.

Coprimary effectiveness outcomes, assessed at 9 months, were mean percent EWL and difference in mean weight loss. Mean percent EWL at 9 months was 26.4% in the IGB group and 10.1% in the control group (difference, 16.2%; 95% CI, 12.3% to 20.2%; p<0.001). Mean weight loss at 9 months was -8.8 kg (-19.4 lb) in the IGB group and -3.2 kg (-7.1 lb) in the control group (p<0.001). There were also significant between-group differences in mean weight loss and mean percent EWL at 6 and 12 months.

As in the trial on the Reshape Duo device, most adverse events in the Obera pivotal trial were anticipated accommodate symptoms. A total of 139 (87%) patients reported nausea, 121 (76%) reported vomiting, and 92 (58%) reported abdominal pain. Fewer than 5% of these adverse events were serious; most were mild or moderate. Thirty patients in the device group had the IGB removed before month 6 because of an adverse event (n=15) or patient request (n=15). There were no deaths and 9 serious adverse events unrelated to device accommodation; among others, they included a case of gastric outlet obstruction and a case of gastric perforation with sepsis.

The Courcoulas pivotal trial was not blinded or sham-controlled; however, a double-blind sham-controlled randomized trial evaluating the BioEnterics IGB (previously called the Obera device) was published by Genco et al (2006). This crossover trial included 32 obese patients ages 25 to 50 years with a mean BMI of 47.3 kg/m². Patients received, in random order, 3 months of an IGB and 3 months of sham. (Both groups underwent upper gastrointestinal endoscopy, but no device was placed in the sham group.) Patients who initially received the IGB had a mean BMI reduction of 5.8 kg/m² after 3 months; after crossover to sham, they had a mean additional BMI reduction of 1.1 kg/m². Patients initially in the sham group had an initial mean BMI reduction of 0.4 kg/m²; after crossover to an active device, they had a mean BMI reduction of 5.1 kg/m². The between-group difference in BMI reductions was statistically significant (p<0.001). Findings on other outcomes (mean percent EWL, mean weight loss) were similar.

Case Series
A case series of patients treated with an IGB with up to 60-month follow-up was published by Kotzampassi et al (2012). A total of 500 patients were treated with the BioEnterics IGB. Twenty-six patients did not complete the initial 6 months of treatment, and another 77 patients did not comply with dietary restrictions and did not have satisfactory weight loss at 6 months. Among 352 patients with data available, BMI was 44.5 kg/m² at baseline, 35.7 kg/m² at device removal, 38.8 kg/m² 12 months after device removal, and 40.1 kg/m² 24 months after device removal. Mean percent EWL was 43.9% at device removal, 27.7% 12 months after device removal, and 17% 24 months after device removal. Among the 195 patients with available 5-year data, mean baseline BMI was 43.3 kg/m², mean BMI at device removal was 33.8 kg/m², and mean BMI at 5 years was 40.1 kg/m². Mean percent EWL at 5 years was 13.0%. Overall, patients who initially complied with 6 months of IGB device use and lost weight slowly gained weight overtime but weighed less at final follow-up than at baseline.

Section Summary: Intragastric Balloon Devices
Evidence includes RCTs, a case series with long-term follow-up on one of the devices, and systematic reviews on various IGB devices. RCTs have found significantly better weight loss
outcomes with IGB devices compared with sham treatment or lifestyle therapy alone. One RCT followed patients for an additional 6 months after IGB removal and found sustained weight loss. A large case series with follow-up up to 5 years has suggested that patients regain weight over time. Additional long-term follow-up data are needed. There are some adverse events, and in a minority of cases, these adverse events can be severe. The FDA wrote 2 letters in 2017 to health care providers, one warning of spontaneous balloon inflation and pancreatitis and the other reporting 5 unanticipated deaths occurring in 2016-2017 following the IGB procedure. Health care providers are encouraged to monitor patients receiving IGBs.

**Aspiration Therapy Device**

Aspiration therapy involves an FDA-approved device (AspireAssist) that allows patients to drain a portion of the stomach contents after meals via an implanted tube connected to an external skin port. One RCT has been published. The trial, by Thompson et al (2017), randomized 207 participants to 52 weeks of AspireAssist therapy plus lifestyle counseling (n=127) or lifestyle counseling alone (n=70). Participants were between 21 and 65 years of age, with a BMI ranging from 35 to 55 kg/m². Coprimary outcomes were mean EWL at 52 weeks and the proportion of patients with 25% or more EWL at 52 weeks. Investigators did a modified intention-to-treat analysis including all patients in the AspireAssist group who attempted tube placement (n=111) and all patients in the lifestyle counseling group who attended at least 1 therapy session (n=60). Mean EWL at 52 weeks was 31.5% in the AspireAssist group and 9.8% in the lifestyle counseling group. The difference between groups was 21.7% (95% CI, 15.3% to 28.1%), which was greater than the 10% difference needed to meet the a priori definition of success. The proportion of patients with 25% or more EWL at 52 weeks was 58.6% in the AspireAssist group and 22% in the lifestyle counseling group (p<0.001). Bulimia or binge eating disorder were exclusion criteria and, during the study, there was no evidence that patients developed bulimia or that devices were overused (i.e., used >3 times a day). Most of the adverse events (∼90%) in the AspireAssist group were associated with placement of a percutaneous endoscopic gastric tube. All 5 serious adverse events occurred in the AspireAssist group (mild peritonitis, severe abdominal pain and a case of product malfunction). The durability of a treatment effect beyond 1 year was not reported.

In addition to the RCT, a case series by Noren and Forssell (2016) evaluated AspireAssist use by 25 obese patients. Patients had 1 year of aspiration therapy and also participated in a cognitive-behavioral therapy weight loss program for the initial 3 months. Patients were instructed to aspirate 3 times a day after meals. Twenty (80%) patients completed the 1-year intervention period. Mean baseline weight was 107.4 kg. In a per-protocol analysis, the mean EWL was 54.5% at 12 months. Data on 15 (60%) patients were available at 24 months; mean EWL was 61.5%.

**Section Summary: Aspiration Therapy Device**

The evidence consists of an RCT with 1-year follow-up and a small case series with up to 2 years of follow-up. The RCT found significantly greater weight loss (measured several ways) with aspiration therapy compared with lifestyle therapy at 1 year. The case series followed only 15 patients more than 1 year; at 2 years, study completers had not regained weight and instead had lost additional excess weight. The total amount of data on aspiration therapy remains limited and additional studies need to be conducted before conclusions can be drawn about the long-term effects of treatment on weight loss, metabolism, and nutrition.

**Revision Bariatric Surgery**

A number of studies have evaluated the efficacy of revision procedures after failed bariatric surgery and reported satisfactory weight loss and resolution of comorbidities with somewhat higher complication rates than with primary surgery. Sudan et al (2015) reported on safety and efficacy outcomes for reoperative bariatric surgeries using data from a national registry, the Bariatric Outcomes Longitudinal Database. The Bariatric Outcomes Longitudinal Database was a large, multi-institutional bariatric surgery-specific database to which data were submitted from 2007 through 2012 by 1029 surgeons and 709 hospitals participating in the Bariatric Surgery Centers of Excellence program. Surgeries were classified as primary or reoperative bariatric.
Reoperations were further divided into corrective surgeries (when complications or incomplete treatment effect of a previous bariatric operation was addressed, but the initial operation was not changed) or conversions (when an index bariatric operation was changed to a different type of bariatric operation or a reversal restored original anatomy.) Of 449,473 bariatric operations in the database, 420,753 (93.6%) operations had no further reoperations (primary operations) while 28,720 (6.3%) underwent reoperations. Of the reoperations, 19,970 (69.5%) were corrective and 8750 (30.5%) were conversions. The primary bariatric operations were RYGB (n=204,705 [49.1%]), LAGB (n=153,142 [36.5%]), SG (n=42,178 [10%]), and BPD-DS (n=4260 [1%]), with the rest classified as miscellaneous. LAGB was the most common primary surgery among conversions (57.5% of conversions; most often [63.5%] to RYGB). Compared with primary operations, mean hospital length of stay was longer for corrections (2.04 days vs 1.8 days, p<0.001) and for conversions (2.86 days vs 1.8 days, p<0.001). Mean percent EWL at 1 year was 43.5% after primary operation, 39.3% after conversions, and 35.9% after corrective operations (statistical comparison not reported). One-year mortality was higher for conversions (0.31%) than for primary surgeries (0.17% p<0.001), with no statistically significant difference for corrections (0.24%) compared with primary surgeries (0.17% p=NS). One-year serious adverse event rates were higher for conversions (3.61%) than for primary operations (1.87% p<0.001), with no statistically significant difference for corrections (1.9%) compared with primary operations (1.87%; p=NS). The authors concluded that reoperation after primary bariatric surgery is relatively uncommon, but generally safe and efficacious when it occurs.

Brethauer et al (2014) conducted a systematic review of reoperations after primary bariatric surgery for the American Society for Metabolic and Bariatric Surgery that included 175 studies, most of which were single-center retrospective reviews. The review is primarily descriptive, but made the following conclusions:

"The current evidence regarding reoperative bariatric surgery includes a diverse group of patient populations and procedures. The majority of the studies are single institution case series reporting short- and medium-term outcomes after reoperative procedures. The reported outcomes after reoperative bariatric surgery are generally favorable and demonstrate that additional weight loss and co-morbidity reduction is achieved with additional therapy. The risks of reoperative bariatric surgery are higher than with primary bariatric surgery and the evidence highlights the need for careful patient selection and surgeon expertise."

**Endoscopic Revision Procedures**

While bariatric surgery revision or correction can be conducted using standard surgical approaches, novel endoscopic procedures are being developed. Some procedures use devices also being evaluated for the endoscopic treatment of GERD (see Blue Shield of California Medical Policy: Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease). The published data on the use of these devices for treatment of regained weight is limited. Published case series have reported results using a number of devices and procedures (including sclerosing injections) as a treatment for this condition. The largest series (2007) found involved 28 patients treated with a sclerosing agent (sodium morrhuate). Reported trials that used one of the suturing devices had fewer than 10 patients. For example, Herron et al (2008) reported on a feasibility study in animals. Thompson et al (2006) reported on a pilot study with changes in anastomotic diameter and weight loss in 8 patients who regained weight and had dilated gastrojejunal anastomoses after RYGB. No comparative trials were identified; comparative trials are important because of the known association between an intervention and short-term weight loss.

The StomaphyX device, which has been used in this approach, was cleared by the FDA through the 510(k) process. It was determined to be equivalent to the EndoCinch system, which has 510(k) marketing clearance for endoscopic suturing for gastrointestinal tract surgery. Eid et al (2014) reported on results from a single-center RCT that compared the StomaphyX device with a sham procedure for revisions in patients with prior weight loss after RYGB at least 2 years earlier. Enrollment was initially planned for 120 patients, but the trial was stopped prematurely after 1-
year follow-up was completed by 45 patients in the StomaphyX group and 29 patients in the sham control group because preliminary analysis failed to achieve the primary efficacy end point in at least 50% of StomaphyX patients. The primary 12-month efficacy end point (reduction in pre-RYGB excess weight by ≥15%, excess BMI loss, and BMI <35 kg/m²) was achieved by 10 (22.2%) of 45 in the StomaphyX group and 1 (3.4%) of 29 in the sham control group (p<0.01).

A 2009 survey of American Society for Metabolic and Bariatric Surgery members (bariatric surgeons) indicated different risk tolerance and weight loss expectations for primary and revisional endoscopic procedures. They were “willing to accept less weight loss and more risk for revisional endoluminal procedures than for primary endoluminal procedures.” The durability of the procedures was a concern, and most surgeons were unwilling to consider the procedures until their efficacy has been proven. A 2013 systematic review of studies reporting outcomes after endoluminal revision of primary bariatric surgery conducted by American Society for Metabolic and Bariatric Surgery concluded: “The literature review shows the procedures on the whole to be well tolerated with limited efficacy. The majority of the literature is limited to small case series. Most of the reviewed devices are no longer commercially available.”

Section Summary: Revision Bariatric Surgery
For surgical revision of bariatric surgery after failed treatment, evidence from nonrandomized studies suggests that revisions are associated with improvements in a weight similar to those seen in primary surgery. However, the published scientific literature on the use of endoscopic devices and procedures in patients who regain weight after bariatric surgery is very limited.

Bariatric Surgery as a Treatment for Type 2 Diabetes
Current indications for bariatric surgery view poorly or uncontrolled diabetes as a comorbidity whose presence supports the need for surgery in patients with a BMI of 35 to 40 kg/m². There also is growing interest in gastrointestinal surgery to treat patients with type 2 diabetes (T2D) in patients with lower BMI. This section focuses on RCTs and systematic reviews of RCTs comparing bariatric surgery with medical therapy.

Type 2 Diabetes and Body Mass Index 30 to 34.9 kg/m²
Wu et al (2016) published a meta-analysis of studies comparing bariatric surgery with nonsurgical interventions for patients who had T2D. Eight RCTs with 619 patients were included. RCTs addressed RYGB (six studies), LAGB (three studies), laparoscopic SG (one study), and BPD (one study). Mean BMI across studies was 29 kg/m² or higher; in 6 of 8 studies, mean BMI was 35 kg/m² or higher. One study had a 5-year follow-up, and the others had 1 to 3 years of follow-up. The study with a 5-year follow-up, by Mingrone et al (2015), was limited to patients with a BMI of at least 35 kg/m². All 8 studies reported remission of T2D as an efficacy end point. A pooled analysis found a significantly higher rate of T2D remission in the bariatric surgery vs the nonsurgical treatment group (relative risk, 5.76; 95% CI, 3.15 to 10.55; p<0.001). Another diabetes-related outcome (mean reduction in HbA1c levels) was significantly greater after bariatric surgery than nonsurgical treatment (MD = -1.29; 95% CI, -1.70 to -0.87). Also, there was a significantly greater reduction in BMI with bariatric surgery than with nonsurgical treatment (MD = -5.80; 95% CI, -6.95 to -4.64; p<0.001).

Since the publication of the Wu meta-analysis, 5-year follow-up has been reported for the Schauer RCT, which is shown in Table 11. When the Wu meta-analysis was published, only 3-year findings of the Schauer study were available. The study included patients with T2D who had BMI 27-43 kg/m². The RCTs are evaluating bariatric surgery in patients with T2D, including the 5-year follow-up of the Schauer study, are summarized in Table 11.

Observational studies evaluating patients undergoing bariatric surgery in patients with T2D with a follow-up to 3 or more years are shown in Table 12.

Muller-Stich et al (2015) published a systematic review of RCTs and observational studies on bariatric surgery in patients with T2D and a BMI less than 35 kg/m². Eleven comparative trials of
medical therapy vs bariatric surgery were included, with 5 RCTs and 6 nonrandomized comparative studies identified. Follow-up was between 1 and 3 years. The primary outcome reported was remission of diabetes. On combined analysis, bariatric surgery was associated with a higher remission rate than medical therapy (OR=14.1; 95% CI, 6.7 to 29.9; p<0.001). On secondary outcomes, surgery was associated with a greater decrease in BMI (MD = -5.5 kg/m²; 95% CI, -6.7 to -4.3 kg/m², p<0.001), a lower HbA₁c level (MD = -1.4%; 95% CI, -1.9% to -0.9%; p<0.001), lower rates of hypertension (OR=0.25; 95% CI, 0.12 to 0.50; p<0.001), and lower rates of dyslipidemia (OR=0.21; 95% CI, 0.10 to 0.44; p<0.001).

Also, Rao et al (2015) published a meta-analysis of short-term outcomes for patients with T2D and a BMI of 35 kg/m² or less who underwent RYGB.101 Nine articles were included (total N=343 patients). After 12 months, patients with T2D had a significant decrease in BMI (weighted mean difference, -7.42; 95% CI, -8.87 to -5.97; p<0.001) and improvements in HbA₁c levels (weighted mean difference, -2.76; 95% CI, -3.41 to -2.11; p<0.000). Reviewers reported that longer term follow-up would be needed.

Previously, a 2012 TEC Assessment evaluated bariatric surgery in diabetic patients with a BMI less than 35 kg/m².102 The evidence consisted mainly of case series. The Assessment identified only observational studies. Based on the data, the Assessment concluded that gastric bypass met TEC criteria as a treatment for diabetes in patients with a BMI less than 35 kg/m² but that other procedures did not meet the TEC criteria for this indication:

- There were no randomized trials comparing bariatric surgery with medical treatment for diabetic subjects with a BMI less than 35 kg/m². There was only 1 randomized trial comparing 2 bariatric procedures. Therefore, studies were categorized by procedure type and presented as case series, regardless of the underlying study type.
- Nine studies reported diabetes remission rates and other outcomes in subjects undergoing gastric bypass. Diabetes remission rates varied between 48% and 100% at follow-up times of 1 year and beyond. One study was a randomized trial of gastric bypass vs SG; in it, diabetes remission associated with gastric bypass was 93% vs 47% for SG at 1 year.
- Two studies reported outcomes of SG. Diabetes remission rates were 55% and 47% at 1 year.
- One study reported outcomes of ileal interposition. The diabetes remission rate at a mean follow-up time of 39.1 months was 78.3%.
- Two studies reported outcomes of gastric banding. The outcomes reported were not considered to be rigorous, because the only measure of diabetes outcome was the withdrawal of diabetes medication. Reported remission rates were 27.5% and 50% at variable follow-up times.
- One study of BPD reported a remission rate of 67% for subjects with a BMI between 30 and 35 kg/m² and 27% for subjects with a BMI between 25 and 30 kg/m² at 12-month follow-up.
- One study reported outcomes of duodenojejunal exclusion. Subjects in this study had more severe diabetes than subjects enrolled in other studies; 100% were on insulin treatment, and the duration of diabetes was between 5 and 15 years. The diabetes remission rate was 17% at 6 months.

Section Summary: Type 2 Diabetes and Body Mass Index 30 to 34.9 kg/m²

Systematic reviews of RCTs and observational studies have found that certain types of bariatric surgery are more efficacious than medical therapy as a treatment for T2D in obese patients, including those with a BMI between 30 and 34.9 kg/m². The greatest amount of evidence assesses gastric bypass, with some comparative studies on LAGB, LSG, and BPD. Systematic reviews have found significantly greater remission rates of diabetes, decrease in HbA₁c levels, and decrease in BMI with bariatric surgery than with nonsurgical treatment. The efficacy of surgery is balanced against the short-term risks of the surgical procedure. Most RCTs in this population have 1 to 3 years of follow-up; 1 RCT, which included patients with BMI between 30 and 34.9 kg/m², had 5-year follow-up data.
<table>
<thead>
<tr>
<th>Study (Country)</th>
<th>N</th>
<th>BMI Range, kg/m²</th>
<th>Patients with BMI ≤35 kg/m²</th>
<th>Length of FU, years</th>
<th>Definition Diabetes Remission</th>
<th>Diabetes Remission Rate, n/n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dixon et al (2008)</td>
<td>60</td>
<td>30-40</td>
<td>22%</td>
<td>2</td>
<td>% achieving FBS &lt;126 mg/dL, HbA₁c &lt;6.2% (off meds)</td>
<td>22/30 (93%) Control (HIL/A₁C-R) 4/30 (13%) p &lt;0.001</td>
</tr>
<tr>
<td>Ikramuddin et al (2015)</td>
<td>120</td>
<td>30-40</td>
<td>59%</td>
<td>2</td>
<td>% achieving all 3 ADA goals: • HbA₁c &lt;7.0% • LDL &lt;2.59 mmol/L • SBP &lt;130 mm Hg</td>
<td>26/60 (43%) Control (HIL/A₁C-R) 8/59 (14%) p &lt;0.001</td>
</tr>
<tr>
<td>Liang et al (2013)</td>
<td>108</td>
<td>&gt;28³</td>
<td>1</td>
<td>T2D remission³b</td>
<td></td>
<td>28/31 (90%) Control1 (GCP/A₁C-S) 0% Control2 (GCP/A₁C-S) 0% p &lt;0.05</td>
</tr>
<tr>
<td>Courcoulas et al (2015)</td>
<td>61</td>
<td>30-40</td>
<td>43%</td>
<td>3</td>
<td>Partial: HbA₁c &lt;6.5% Full: HbA₁c &lt;5.7% (off meds)</td>
<td>8/20 (40%) Surgery (LAGB) 0% Control (HIL/A₁C-S) 0% 0.004</td>
</tr>
<tr>
<td>Schauer et al (2017)</td>
<td>150</td>
<td>27-43</td>
<td>37%</td>
<td>5ʰ</td>
<td>% HbA₁c &lt;6.0% (± meds)</td>
<td>14/49 (29%) Surgery (LSG) 11/49 (23%) Control (HIL/A₁C-S) 2/38 (5%) p 0.01²/0.03³</td>
</tr>
<tr>
<td>Mingrone et al (2015)</td>
<td>60</td>
<td>35+</td>
<td>0%</td>
<td>5</td>
<td>% HbA₁c ≤6.5% (± meds ×1 y)</td>
<td>8/19 (42%) Surgery (BPD) 13/19 (68%) Control (GCP/A₁C-S) 0% p &lt;0.001</td>
</tr>
</tbody>
</table>
### Study (Country) | N | BMI Range, kg/m² | Patients with BMI ≤35 kg/m² | Length of FU, years | Definition Diabetes Remission | Diabetes Remission Rate, n/n (%) |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgery (LAGB)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wentworth et al (2014)</td>
<td>51</td>
<td>25-30</td>
<td>100%</td>
<td>2</td>
<td>&lt;125 mg/dL or 200 mg/dL 2-h OGGT (off meds x2 d)</td>
<td>12/23 (52%)</td>
</tr>
<tr>
<td><strong>Control (IL/I/A1C-R)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2/25 (8%) 0.001</td>
</tr>
<tr>
<td><strong>Surgery (RYGB)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Halperin et al (2014)</td>
<td>43</td>
<td>30-42</td>
<td>30%</td>
<td>1</td>
<td>% HbA1c &lt;6.5%</td>
<td>11/19 (58%)</td>
</tr>
<tr>
<td><strong>Control (HIL/A1C-S)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3/19 (16%) 0.03</td>
</tr>
</tbody>
</table>


### Table 12. Observational Studies Assessing Bariatric Surgery in Patients with Type 2 Diabetes With Follow-Up ≥3 Years

<table>
<thead>
<tr>
<th>Study (Country)</th>
<th>N</th>
<th>BMI Range, kg/m²</th>
<th>Patients with BMI ≤35 kg/m²</th>
<th>Length of FU</th>
<th>Interv</th>
<th>Mean HbA1c</th>
<th>Mean BMI, kg/m²</th>
<th>Diabetes Remission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scopinaro et al (2014)</td>
<td>20 treated; 27 matched diabetic controls</td>
<td>30-34.9</td>
<td>100%</td>
<td>3 y</td>
<td>RYGB</td>
<td>9.5%</td>
<td>32.9</td>
<td>26.0a</td>
</tr>
</tbody>
</table>

### Notes:

- All RCTs in this table are in the Wu et al (2016) meta-analysis; 7 of the 8 (except Mingrone et al) are in the Muller-Stich et al (2015) meta-analysis; the Rao et al (2015) meta-analysis and the TEC Assessment did not include RCTs. No additional RCTs comparing bariatric surgery with nonsurgical treatment in patients who had T2D were identified.
- Used as a secondary outcome. Primary outcome was change in left ventricular mass index.
- Unadjusted (RYGB vs control).
- Unadjusted (LSG vs control).
- RYGB vs control.
- LSG vs control.
- WHO Asia-Pacific Obesity Classification.
<table>
<thead>
<tr>
<th>Study (Country)</th>
<th>N</th>
<th>BMI Range, kg/m²</th>
<th>Patients with BMI ≤35 kg/m²</th>
<th>Length of FU</th>
<th>Interv</th>
<th>Mean HbA₁₅</th>
<th>Mean BMI, kg/m²</th>
<th>Diabetes Remission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>DePaula et al (2012)¹¹³ (Brazil)</td>
<td>202</td>
<td>&lt;35</td>
<td>100%</td>
<td>39 mo</td>
<td>SG</td>
<td>8.7%</td>
<td>29.7</td>
<td>2 y: 13/20 (65%)</td>
</tr>
<tr>
<td>Lee et al (2008)¹¹⁴ (Taiwan)</td>
<td>544 bypass</td>
<td>32-77</td>
<td>Not reported</td>
<td>3 y</td>
<td>Bypass</td>
<td>6.2%</td>
<td>41.3</td>
<td>Not reported</td>
</tr>
<tr>
<td>Group 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>116 LAGB</td>
<td>Not reported</td>
<td>LAGB</td>
<td>5.9%</td>
<td>5.2%</td>
<td>41.9</td>
<td>32.7</td>
<td>Not reported</td>
</tr>
</tbody>
</table>

Group 1 is defined as poor control optimal medical management (may include insulin). Group 2 is defined as adequate control with medication (may include insulin).


a p<0.05 (follow-up vs baseline).
b Estimated from figure.
c Mean.
Bariatric Surgery in Nondiabetic Patients with a Body Mass Index Less Than 35 kg/m²
A 2012 TEC Assessment evaluated LAGB in individuals without diabetes who had a BMI less than 35 kg/m². This Assessment was prompted by FDA approval of LAP-BAND for this indication in 2011. The TEC Assessment concluded that LAGB did not meet TEC criteria in these patients and made the following summary statements:

- The evidence on LAGB for patients with lower BMIs is limited both in quantity and quality. There was only 1 small RCT, which had methodologic limitations, a nonrandomized comparative study based on registry data, and several case series. Using the GRADE evaluation, the quality of evidence on the comorbidity outcomes was judged to be low, and the quality of the evidence on the weight loss outcomes was judged to be moderate.
- The evidence was sufficient to determine that weight loss following LAGB is greater than with nonsurgical therapy.
- Direct data on improvement in weight-related comorbidities was lacking. The limited evidence was not sufficient to conclude that the amount of weight loss is large enough that improvements in weight-related comorbidities could be assumed.
- There were very few data on quality of life in this population of patients.
- The frequency and impact of long-term complications following LAGB were uncertain, and this uncertainty has been one of the main reasons why it is difficult to determine whether the benefit of LAGB outweighs the risk for this population. While the short-term safety of LAGB has been well-established, the long-term adverse events occur at a higher rate and are less well-defined.

Section Summary: Bariatric Surgery in Nondiabetic Patients with a Body Mass Index Less Than 35 kg/m²
There is limited evidence for bariatric surgery in patients who are not diabetic or morbidly obese. A few small RCTs and case series have reported a loss of weight and improvements in comorbidities for this population. However, the evidence does not permit conclusions on the long-term risk-benefit ratio of bariatric surgery in this population.

Bariatric Surgery in Morbidly Obese Adolescent Children

Bariatric Surgery Techniques

Systematic Reviews
Qi et al (2017) published a systematic review and meta-analysis on the use of bariatric surgery for the treatment of adolescents with obesity (see Table 13). In a literature search conducted through July 2017, 49 studies were identified for inclusion. Study quality was assessed using the Newcastle-Ottawa Scale. Age of patients ranged from 14 to 20 years. BMI ranged from 34 to 63 kg/m². Overall results showed significant improvements in BMI as well as glycemic and lipid control with various bariatric surgery techniques (see Table 14). RYGP showed the largest improvements compared with other procedures, with LAGB and sleeve gastrectomy also showing improvements in this population.

In a systematic review of 23 studies, Black et al (2013) concluded that the available literature demonstrated a high rate of significant short-term weight loss after bariatric surgery (see Table 13). The literature search was conducted through January 2013. Quality assessment of the included studies was not discussed. Ages of patients at the time of surgery ranged from 5 to 23 years. A meta-analysis showed significant reductions in BMI (see Table 14). Meta-analyses were not conducted on the resolution of comorbidities due to heterogeneity in reporting. However, most cases of hypertension, OSA, T2D, and dyslipidemia were reported to have resolved at 1-year follow-up. Reviewers noted that complication and comorbidity rates were not well-defined.

Treadwell et al (2008) conducted a systematic review and meta-analysis of the published evidence on bariatric surgery in adolescents (see Table 13). Their analysis included English-language articles on currently performed procedures when data were separated by procedure, and there was a minimum 1-year follow-up for weight and BMI. Studies must have reported
outcomes data for 3 or more patients ages 21 years or younger, representing at least 50% of pediatric patients enrolled at that center. Nineteen studies reported on between 11 and 68 patients who were 21 years or younger. Eight studies of LAGB (mean BMI, 45.8 kg/m²; median age range, 15.6-20 years); 6 studies on RYGB (mean BMI, 51.8 kg/m²; median age range, 16-17.6 years); 5 studies of other procedures (mean BMI, 48.8 kg/m²; median age range, 15.7-21 years) were included.

Meta-analyses of BMI at longest follow-up indicated sustained and clinically significant reductions for both LAGB and RYGB (see Table 14). Comorbidity resolution was sparsely reported, but surgery appeared to resolve some medical conditions, including diabetes and hypertension; 2 studies of LAGB showed large rates of diabetes resolution but low patient enrollment, and only 1 study of RYGB reported relevant data. No in-hospital or postoperative deaths were reported in any LAGB study. The most frequently reported complications for LAGB were band slippage and micronutrient deficiency with sporadic cases of band erosion, port/tube dysfunction, hiatal hernia, wound infection, and pouch dilation. More severe complications were reported for RYGB, such as pulmonary embolism, shock, intestinal obstruction, postoperative bleeding, staple line leak, and severe malnutrition. No in-hospital deaths were reported; however, 1 patient died 9 months after the study with severe Clostridium difficile colitis; three others died of causes not likely to have been directly related to the bariatric surgeries. No LAGB studies reported data on the impact of surgery on growth and development. One study of RYGB reported pre- and postoperative heights and concluded that there was no evidence of growth retardation at an average follow-up of 6 years, but it could not be determined from the data whether expected growth was achieved.

### Table 13. Systematic Review Characteristics for Bariatric Surgery for Adolescents with Obesity

<table>
<thead>
<tr>
<th>Study</th>
<th>Dates</th>
<th>Studies</th>
<th>Participants</th>
<th>Design</th>
<th>Duration</th>
</tr>
</thead>
</table>
• LAGB: 1028  
• LSG: 665  
• Other: 98 | • 1 RCT  
• 22 prospective  
• 26 retrospective | 12-120 mo |
• LAGB: 271  
• LSG: 90  
• Other: 20 | • 1 controlled  
• 22 uncontrolled | 6-120 mo |
• LAGB: 352  
• Other: 158 | • 1 prospective  
• 17 retrospective | 0.22 y |


### Table 14. Systematic Review Results for Bariatric Surgery for Adolescents with Obesity

<table>
<thead>
<tr>
<th>Study</th>
<th>BMI Reduction Mean Difference (95% CI)</th>
<th>Fasting Blood Insulin, mIU/L Mean Difference (95% CI)</th>
<th>Total Cholesterol, mg/dL Mean Difference (95% CI)</th>
</tr>
</thead>
</table>
| Qi et al (2017) | 18.5 (16.4 to 20.7)  
12.1 (11.0 to 13.3)  
16.0 (13.2 to 20.7)  
23.2 (15.6 to 30.7) | 24.8 (10.0 to 30.7)  
20.5 (16.4 to 24.6)  
18.4 (11.4 to 25.3)  
28.3 (5.7 to 50.9) | 29.4 (18.1 to 40.7)  
2.2 (-10.0 to 14.4)  
13.6 (2.9 to 24.2)  
49.5 (29.9 to 69.2) |
| Black et al (2013) | 17.2 (14.3 to 20.1)  
10.5 (9.1 to 11.8)  
14.5 (11.7 to 17.3)  
NR | NR  
NR  
NR  
NR | NR  
NR  
NR  
NR |
| Treadwell et al (2008) | 17.8 to 22.3  
10.6 to 13.7 | NR  
NR | NR  
NR |
BMI: body mass index; CI: confidence interval; LAGB: laparoscopic adjustable gastric banding; LSG: laparoscopic sleeve gastrectomy; NR: not reported; RYGP: Roux-en-Y gastric bypass;

a No point estimate provided, only 95% CIs given.

**Observational Studies**

One of the larger observational studies included in the systematic reviews was by Inge et al (2014), who reported results from the Teen-Longitudinal Assessment of Bariatric Surgery study, a prospective, multicenter observational study of bariatric surgery in patients ages 19 or younger.119 The study enrolled 242 patients, with a mean age 17.1 years and median BMI of 50.5 kg/m² (IQR, 45.2-58.2 kg/m²) at the time of surgery. All patients had at least 1 obesity-related comorbidity, most commonly dyslipidemia (74%), followed by OSA (57%), back and joint pain (46%), hypertension (45%), and fatty liver disease (37%). Gastric bypass, LAGB, and vertical SG were performed in 66.5%, 5.8%, and 27.7% of patients, respectively. Within 30 days of surgery, 20 major complications occurred in 19 (7.9%) patients, most of which were perioperative. The cohort is being followed to assess longer term outcomes.

**Gastric Bypass**

**Comparative Studies**

Olbers et al (2017) published results from the Adolescent Morbid Obesity Surgery study.120 Adolescent Morbid Obesity Surgery is a prospective, nonrandomized study of patients ages 13 to 18 years with severe obesity. Enrolled patients underwent RYGB (n=81) and were compared with 80 matched adolescent controls undergoing conservative treatment and 81 matched adult controls undergoing RYGB. The primary outcome was change in BMI after 5 years. Adolescents undergoing RYGB had a mean age of 16.5 years and mean BMI of 45.5 kg/m². At 5-year follow-up, adolescents receiving RYGB experienced a mean reduction in BMI of 13.1 kg/m² (95% CI, 11.8 to 14.5 kg/m²). Adolescents receiving conservative treatment experienced a mean increase in BMI of 3.3 kg/m² (95% CI, 1.1 to 4.8 kg/m²). Adult controls receiving RYGB experienced a reduction in BMI similar to the adolescents undergoing RYGB, 12.3 kg/m² (95% CI, 10.9 to 13.7 kg/m²). Adolescents undergoing RYGB also experienced significant improvements in glucose, insulin, cholesterol, and blood pressure levels compared with adolescents in the control group.

**Laparoscopic Adjustable Gastric Banding**

**Systematic Reviews**

Willcox and Brennan (2014) conducted a systematic review focusing on studies reporting biopsychosocial outcomes following LAGB in adolescents with obesity.121 The literature search, conducted through May 2013, identified 11 studies for inclusion. Significant weight loss was reported in all studies. Resolution of comorbidities was also reported, though the evidence was poor quality due to a limited discussion of comorbidity assessment criteria. Reporting of psychosocial outcomes was considered limited, with reviewers concluding that further research is needed to better understand the behavioral, emotional, and social factors experienced by adolescents undergoing LAGB.

**Randomized Controlled Trials**

In the only RCT identified in the systematic reviews, O’Brien et al (2010) reported on 50 adolescents between the ages of 14 and 18 years with a BMI 35 kg/m² or higher who received either a lifestyle intervention or LAGB.3 Follow-up was 2 years. Twenty-four of 25 patients in the gastric banding group and 18 of 25 in the lifestyle group completed the study. Twenty-one (84%) in the gastric banding group and 3 (12%) in the lifestyle group lost more than 50% of excess weight. Overall, mean weight loss in the gastric banding group was 34.6 kg (95% CI, 30.2 to 39.0 kg), representing an EWL of 78.8% (95% CI, 66.6% to 91.0%). Mean losses in the lifestyle group were 3.0 kg (95% CI, 2.1 to 8.1 kg), representing an EWL of 13.2% (95% CI, 2.6% to 21.0%). The gastric banding group experienced improved quality of life with no perioperative adverse events; however, 8 (33%) surgeries were required in 7 patients for revisional procedures, either for proximal pouch dilatation or tubing injury during follow-up.
Case Series
There are many case series of bariatric surgery in adolescents, and they have generally reported weight loss in the same range reported for adults. For example, Nadler et al (2008) reported on 73 patients ages 13 to 17 years who had undergone LAGB since 2001 at the authors’ institution. Mean preoperative BMI was 48 kg/m². EWL at 6 months, 1 year, and 2 years postoperatively was 35%, 57%, and 61%, respectively. Six patients developed band slippage, and three developed symptomatic hiatal hernias. Nutritional complications included an asymptomatic iron deficiency in 13 patients, asymptomatic vitamin D deficiency in 4 patients, and mild subjective hair loss in 14. In the 21 patients who entered the authors’ FDA-approved study and had reached 1-year follow-up, 51 comorbid conditions were identified, 35 of which completely resolved, 9 were improved, 5 were unchanged, and 2 were aggravated after 1 year.

Sleeve Gastrectomy
Manco et al (2017) published results from contemporaneous cohorts of adolescent patients with BMI of 35 kg/m² or more and nonalcoholic steatohepatitis who chose between 3 treatment options. Twenty patients chose to undergo laparoscopic SG, 20 patients opted to ingest intragastric weight loss devices (IGWLD, either the BioEnterics Intragastric Balloon System or Obalon Gastric Balloon) plus lifestyle interventions, and 53 patients chose lifestyle interventions alone. All patients in the laparoscopic SG and IGWLD groups completed the study; 22 of the 53 in the lifestyle intervention group completed the study. After 1-year follow-up: patients undergoing laparoscopic SG lost 21% body weight; patients treated with IGWLD lost 3% body weight, and patients receiving lifestyle interventions only gained 2% body weight. Nonalcoholic steatohepatitis reverted in 100% of patients receiving laparoscopic SG and in 24% receiving IGWLD. Patients receiving lifestyle interventions alone did not improve significantly.

Section Summary: Bariatric Surgery in Morbidly Obese Adolescents Children
Gastric Bypass, LAGB, and SG
Several systematic reviews and meta-analyses have been conducted on observational studies evaluating the use of bariatric surgery for the treatment of adolescents with obesity. There is an overlap of studies among the systematic reviews. The majority of evidence assesses the use of gastric bypass, SG, or LAGB. Two nonrandomized comparative studies were published after the systematic reviews. One compared RYGB with conservative treatment and with adults undergoing RYGB, and one compared laparoscopic SG with gastric balloons and lifestyle interventions. The evidence on bariatric surgery in adolescents indicates that the percent EWL and change in BMI are approximately the same as that in adults. There are greater concerns for developmental maturity, psychosocial status, and informed consent in adolescents.

Bariatric Surgery Other Than Gastric Bypass, LAGB, and SG
There is less evidence for the use of bariatric techniques other than gastric bypass, LAGB, and SG. Sample sizes are small for these other techniques and meta-analyses have shown wide confidence intervals in the estimates.

Guideline recommendations for bariatric surgery in adolescents lack uniformity but generally correspond to the clinical selection criteria for adults and supplement these clinical selection criteria with greater attention to issues of maturity and psychosocial status.

Bariatric Surgery in Morbidly Obese Preadolescent Children
Black et al (2013; described above) published a systematic review of 23 studies on bariatric surgery in children and adolescents. Most studies were limited to adolescents; only two included children younger than 12 years old. One study, Silberhumer et al (2006), included 9- to 19-year-olds (mean age, 17 years); conclusions could not be drawn about the impact of bariatric surgery in this sample of preadolescent children. Similarly, Alqahtani et al (2012) included children ages 5 to 21 years (mean age, 14 years) and did not provide conclusions separately for preadolescent children.
Clinical practice guidelines (e.g., from the Endocrine Society [2008]\textsuperscript{126} and the Institute for Clinical Systems Improvement [2013]\textsuperscript{127}) have recommended against bariatric surgery in preadolescent children.

**Section Summary: Bariatric Surgery in Morbidly Obese Preadolescent Children**

There are few published data, and no studies were identified that focused on bariatric surgery in preadolescent children. Clinical guidelines have recommended against bariatric surgery in preadolescent children.

**Hiatal Hernia Repair in Conjunction with Bariatric Surgery**

Hiatal hernia is associated with obesity, and existing hiatal hernias may be worsened with bariatric surgery. In some studies, the presence of a hiatal hernia has been associated with complications after LAGB\textsuperscript{128} although other studies have reported no differences in perioperative complications after LAGB in patients with GERD and/or a hiatal hernia or those without GERD and/or hiatal hernia.\textsuperscript{129} Hiatal hernias, either incidentally found at surgery or diagnosed preoperatively, are often repaired at the time of bariatric surgery. In 2013, the Society of American Gastrointestinal and Endoscopic Surgeons published guidelines on the management of hiatal hernia, recommending that, during RYGB, SG, and the placement of LAGBs, all detected hiatal hernias should be repaired (grade of recommendation: weak; evidence quality moderate).\textsuperscript{130}

There is limited evidence whether repair of hiatal hernias at the time of bariatric surgery improves outcomes after surgery; it consists primarily of cohort studies comparing outcomes for patients who had a hiatal hernia and underwent repair during bariatric surgery with patients without a hiatal hernia.

Gulkarov et al (2008) reported on results of a prospective cohort study comparing outcomes for patients who underwent LAGB with or without concurrent hiatal hernia repair (n=1298 with LAGB alone; n=520 with concurrent hiatal hernia repair).\textsuperscript{131} The authors reported that, initially, hiatal hernias were diagnosed based on preoperative esophagram and upper endoscopy, but this was discontinued after these studies were shown to have poor predictive value for small-to-medium size hernias; subsequent patients were diagnosed at the time of surgery. It was not specified how many patients were diagnosed with each method or how many of those had symptoms before gastric banding. Fewer patients who underwent concurrent hiatal hernia repair required reoperation for a complication (3.5% vs 7.9% in the LAGB alone group; p<0.001). Hiatal hernia repair added an average of 14 minutes to surgical time. Weight loss outcomes did not differ significantly between groups.

Santonicola et al (2014) evaluated the effects of LSG with or without hiatal hernia repair on GERD in obese patients.\textsuperscript{132} The study included 78 patients who underwent SG with concomitant hiatal hernia repair for a sliding hiatal hernia diagnosed intraoperatively, compared with 102 patients without a hiatal hernia who underwent SG only. The prevalence of typical GERD symptoms did not improve from baseline to follow-up in patients who underwent concomitant hiatal hernia repair (38.4% presurgery vs 30.8% postsurgery, p=0.3). However, those in the SG only group had a significant decrease in the prevalence of typical GERD symptoms (39.2% presurgery vs 19.6% postsurgery, p=0.003).

Reynoso et al (2011) reported on outcomes after primary and revisional LAGB in patients with a hiatal hernia treated at a single hospital system.\textsuperscript{133} Of 1637 patients with a hiatal hernia undergoing primary gastric banding, 190 (11.6%) underwent concurrent hiatal hernia repair; of 181 patients undergoing revision gastric banding, 15 (8.3%) underwent concurrent hiatal hernia repair. For primary procedures, there were no significant differences in mortality, morbidity, length of stay, and 30-day readmission rates for patients who underwent LAGB with and without hiatal hernia repair. However, this compares patients with a hiatal hernia undergoing repair to patients without a hiatal hernia. The more relevant comparison would be comparing repair to no repair in patients who have a hiatal hernia.
Ardestani et al (2014) analyzed data from the Bariatric Outcomes Longitudinal Database registry to compare outcomes for patients with and without hiatal hernia repair at the time of LAGB. Of 41,611 patients who had LAGB from 2007 to 2010, 8120 (19.5%) had a concomitant hiatal hernia repair. Those with hiatal hernia repair were more likely to have GERD preoperatively (49% vs 40% in the non–hiatal hernia repair group; p < 0.001). Perioperative outcomes were similar between groups. Of those with GERD preoperatively, rates of improvement in GERD symptoms did not differ significantly at 1 year, postprocedure (53% for hiatal hernia repair vs 52% for non–hiatal hernia repair; p = 0.4). Although the hiatal hernia repair added minimal time (mean, 4 minutes) to surgery, the authors concluded that many repairs would have involved small hemias with limited clinical effect.

In general, studies have reported that the addition of hiatal hernia repair at the time of bariatric surgery is safe and feasible. In a small case series of 21 patients, Frezza et al (2008) described the feasibility of cervical repair at the time of LAGB for patients with a hiatal hernia. Al-Haddad et al (2014) used data from the U.S. Nationwide Inpatient Sample to evaluate the surgical risk associated with hiatal hernia repair at the time of bariatric surgery. For laparoscopic RYGB, there were 206,559 and 9060 patients who underwent the procedure alone or with concomitant hiatal hernia repair, respectively. For LAGB, 52,901 and 9893 patients, respectively, underwent the procedure alone or with hiatal hernia repair. The authors reported no evidence of increased risk of perioperative adverse events associated with the concomitant hiatal hernia repair. However, patients who underwent a concomitant hiatal hernia repair were less likely to have prolonged length of stay, with an average treatment effect on the treated of hiatal hernia repair of -0.124 (95% CI, -0.15 to -0.088) for prolonged length of stay for patients who underwent RYGB and an average treatment effect on the treated of hiatal hernia repair of -0.107 (95% CI, -0.159 to -0.0552) for prolonged length of stay for patients who underwent LAGB.

**Section Summary: Hiatal Hernia Repair in Conjunction with Bariatric Surgery**

Hiatal hernia repair is frequently undertaken at the time of bariatric surgery. The evidence related to whether hiatal hernia repair improves outcomes after bariatric surgery is limited, particularly for hiatal hernias that are incidentally diagnosed at the time of surgery. No studies were identified that compared outcomes after bariatric surgery with or without hiatal hernia repair in a population of patients with a known hiatal hernia. For patients with a preoperative diagnosis of a hiatal hernia, symptoms related to a hernia, and indications for surgical repair, it is reasonable to undertake this procedure at the time of bariatric surgery. For other patients, it is uncertain whether repair of a hiatal hernia at the time of bariatric surgery improves outcomes.

**Summary of Evidence**

**Adults with Morbid Obesity**

For individuals who are adults with morbid obesity who receive gastric bypass, the evidence includes RCTs, observational studies, and systematic reviews. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. TEC Assessments and other systematic reviews of RCTs and observational studies found that gastric bypass improves health outcomes, including weight loss and remission of type 2 diabetes. A TEC Assessment found similar weight loss with open and laparoscopic gastric bypass. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who are adults with morbid obesity who receive LAGB, the evidence includes RCTs, observational studies, and systematic reviews. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Systematic reviews of RCTs and observational studies have found that LAGB is a reasonable alternative to gastric bypass. There is less weight loss with LAGB than with gastric bypass, but LAGB is less invasive and is associated with fewer serious adverse events. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.
For individuals who are adults with morbid obesity who receive SG, the evidence includes RCTs, observational studies (evaluating SG alone and comparing SG with gastric bypass), as well as systematic reviews. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Systematic reviews of RCTs and observational studies have found that SG results in substantial weight loss and that this weight loss is durable for at least 5 years. A meta-analysis found that short-term weight loss was similar after SG compared with gastric bypass. Long-term weight loss was greater after gastric bypass, but SG is associated with fewer adverse events. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who are adults with morbid obesity who receive BPD-DS, the evidence includes nonrandomized comparative studies, observational studies, and a systematic review. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Nonrandomized comparative studies have found significantly higher weight loss after BPD-DS compared with gastric bypass at 1 year. A large case series found sustained weight loss after 7 years. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who are adults with morbid obesity who receive BPD without duodenal switch, the evidence includes observational studies and systematic reviews. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. A TEC Assessment reviewed the available observational studies and concluded that weight loss was similar after BPD without a duodenal switch or gastric bypass. However, concerns have been raised about complications associated with BPD without duodenal switch, especially long-term nutritional and vitamin deficiencies. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are adults with morbid obesity who receive VBG, the evidence includes observational studies and systematic reviews. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. A TEC Assessment identified 8 nonrandomized comparative studies evaluating VBG, and these studies found that weight loss was significantly greater with open gastric bypass. Moreover, VBG has relatively high rates of complications, revisions, and reoperations. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are adults with morbid obesity who receive 2-stage bariatric surgery procedures, the evidence includes small RCTs and observational studies. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. There is a lack of evidence that 2-stage bariatric procedures improve outcomes compared with 1-stage procedures. The small RCT compared IGB plus gastric bypass with the standard of care plus gastric bypass and did not detect a difference in weight loss at 6 months postsurgery. Case series have shown relatively high complication rates in 2-stage procedures, and patients are at risk of complications in both stages. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are adults with morbid obesity who receive laparoscopic gastric plication, the evidence includes 2 RCTs, observational studies, and systematic reviews. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. A 2014 systematic review only identified a small nonrandomized comparative study comparing laparoscopic gastric plication with other bariatric surgery procedures. Since the systematic review, 2 RCTs have been
published, one comparing laparoscopic gastric plication with a sham procedure and another comparing laparoscopic gastric plication with SG. Laparoscopic gastric plication was more effective than sham at 1-year follow-up and equally effective as SG at 2-year follow-up. Additional comparative studies and RCTs with longer follow-up are needed to permit conclusions about the safety and efficacy of laparoscopic gastric plication. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are adults with morbid obesity who receive SADI-S, the evidence includes observational studies. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. No controlled trials have evaluated SADI-S. There are a few case series, the largest of which had fewer than 100 patients. A retrospective chart review of patients receiving gastric bypass, BPD, and SADI-S, reported that among patients without diabetes, SADI-S was more effective in weight loss and cholesterol outcomes than gastric bypass. Among patients with diabetes, SADI-S and BDP had higher remission rates than gastric bypass. Comparative studies and especially RCTs are needed to permit conclusions about the safety and efficacy of SADI-S. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are adults with morbid obesity who receive duodenojejunal sleeve, the evidence includes RCTs and systematic reviews. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. A systematic review of duodenojejunal sleeves included 5 RCTs and found significantly greater short-term weight loss (12-24 weeks) with the sleeves compared with medical therapy. There was no significant difference in symptoms associated with diabetes. All RCTs were small and judged by systematic reviewers to be at high-risk of bias. High-quality comparative studies are needed to permit conclusions on the safety and efficacy of the procedure. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are adults with morbid obesity who receive IGB devices, the evidence includes RCTs, systematic reviews, and case series. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. RCTs assessing the 2 IGB devices approved by the Food and Drug Administration have found significantly greater weight loss with IGB than with sham treatment or lifestyle therapy alone after 6 months (maximum length of device use). Some adverse events were reported, mainly related to accommodation of the balloon in the stomach; in a minority of cases, these adverse events were severe. One RCT followed patients for an additional 6 months after IGB removal and found sustained weight loss. There are limited data on the durability of weight loss in the long-term. Comparative data are lacking. A large case series found that patients gradually regained weight over time. Moreover, it is unclear how 6 months of IGB use would fit into a long-term weight loss and maintenance intervention. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who are adults with morbid obesity who receive an aspiration therapy device, the evidence includes an RCT and case series. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. The RCT found significantly greater weight loss with aspiration therapy than lifestyle therapy at 1 year. One small case series reported on 15 patients at 2 years. The total amount of data on aspiration therapy remains limited and additional studies are needed before conclusions can be drawn about the effects of treatment on weight loss, metabolism and nutrition and long-term durability of treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Revision Bariatric Surgery**

For individuals who are adults with morbid obesity and failed bariatric surgery who receive revision bariatric surgery, the evidence includes case series and registry data. Relevant
outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Case series have shown that patients receiving revision bariatric surgery experienced satisfactory weight loss. Data from a multinational bariatric surgery database has found that corrective procedures following primary bariatric surgery are relatively uncommon but generally safe and efficacious. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Adults with Type 2 Diabetes**

For individuals who are diabetic and not morbidly obese who receive gastric bypass, SG, BPD, or LAGB, the evidence includes RCTs, nonrandomized comparative studies, and case series. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Systematic reviews of RCTs and observational studies have found that certain types of bariatric surgery are more efficacious than medical therapy as a treatment for type 2 diabetes in obese patients, including those with a BMI between 30 and 34.9 kg/m². The greatest amount of evidence is on gastric bypass. Systematic reviews have found significantly greater remission rates of diabetes, decrease in hemoglobin A1c levels, and decrease in BMI with bariatric surgery than with nonsurgical treatment. The efficacy of surgery is balanced against the short-term risks of the surgical procedure. Most RCTs in this population have 1 to 3 years of follow-up; 1 RCT that included patients with BMI between 30 and 34.9 kg/m² had 5-year follow-up data. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Nondiabetic and Nonobese Adults**

For individuals who are not diabetic and not morbidly obese who receive any bariatric surgery procedure, the evidence includes RCTs, nonrandomized comparative studies, and case series. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. There is limited evidence for bariatric surgery in patients who are not diabetic or morbidly obese. A few small RCTs and case series have reported a loss of weight and improvements in comorbidities for this population. However, the evidence does not permit conclusions on the long-term risk-benefit ratio of bariatric surgery in this population. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Adolescent Children with Morbid Obesity**

**Gastric Bypass, LAGB, or SG**

For individuals who are adolescent children with morbid obesity who receive gastric bypass, or LAGB, or SG, the evidence includes RCTs, observational studies, and systematic reviews. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Systematic reviews of studies on bariatric surgery in adolescents, who mainly received gastric bypass or LAGB or SG, found significant weight loss and reductions in comorbidity outcomes with bariatric surgery. For bariatric surgery in the adolescent population, although data are limited on some procedures, studies have generally reported that weight loss and reduction in risk factors for adolescents are similar to that for adults. Most experts and clinical practice guidelines have recommended that bariatric surgery in adolescents be reserved for individuals with severe comorbidities, or for individuals with a BMI greater than 50 kg/m². Also, greater consideration should be placed on the patient developmental stage, on the psychosocial aspects of obesity and surgery, and on ensuring that the patient can provide fully informed consent. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

**Bariatric Surgery Other Than Gastric Bypass, LAGB, or SG**

For individuals who are adolescent children with morbid obesity who receive bariatric surgery other than gastric bypass, or LAGB, or SG, the evidence includes systematic reviews and a
Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Studies using bariatric surgery other than gastric bypass, LAGB, or SG, have small sample sizes. Results from a meta-analysis including patients using other procedures have shown significant improvements in BMI reduction, fasting blood insulin, and total cholesterol, although the estimates have wide confidence intervals, limiting interpretation. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Preadolescent Children with Morbid Obesity**
For individuals who are preadolescent children with morbid obesity who receive bariatric surgery, the evidence includes no studies focused on this population. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Several studies of bariatric surgery in adolescents have also included children younger than 12 years old, but findings were not reported separately for preadolescent children. Moreover, clinical practice guidelines have recommended against bariatric surgery for preadolescent children. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Hiatal Hernia Repair with Bariatric Surgery**
For individuals with morbid obesity and a preoperative diagnosis of a hiatal hernia who receive hiatal hernia repair with bariatric surgery, the evidence includes cohort studies and case series. Relevant outcomes are overall survival, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Results from the cohort studies and case series have shown that, when a preoperative diagnosis of a hiatal hernia has been present, repairing the hiatal hernia during bariatric surgery resulted in fewer complications. However, the results are limited to individuals with a preoperative diagnosis. There was no evidence on the use of hiatal hernia repair when the hiatal hernia diagnosis is incidental. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

**Supplemental Information**

**Clinical Input from Physician Specialty Societies and Academic Medical Centers**
While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to the requests from Blue Cross Blue Shield Association, input was received from 1 physician specialty society and 2 academic medical centers on the use of the REALIZE band in 2008. All 3 responses supported the use of the REALIZE band as a surgical option for patients, as adopted into the policy in 2008.

In response to the requests from Blue Cross Blue Shield Association, input was also received from 2 academic medical centers on the use of the new endoscopic placement of devices to remedy weight gain that occurs after bariatric surgery in 2008. Input from both centers agreed that this approach is considered investigational, as adopted in the policy in 2008.

**Practice Guidelines and Position Statements**

**American Association of Clinical Endocrinologists et al**
In 2017, the American Association of Clinical Endocrinologists (AACE) and the American College of Endocrinology jointly published a comprehensive diabetes type 2 management algorithm. The document stated: “Bariatric surgery should be considered for adult patients with a BMI [body mass index] of 35 kg/m² or more and comorbidities, especially if therapeutic goals have not been reached using other modalities.”
In 2016, AACE and the American College of Endocrinology jointly published comprehensive clinical guidelines on the medical care of patients with obesity. The guidelines addressed 9 broad clinical questions with 123 recommendations. It was noted that the 2013 guidelines specifically on bariatric surgery (see below) were considered adequate in the current form. With regard to bariatric surgery for these guidelines, the following recommendations were added to those in the 2013 guideline (see Table 15).

### Table 15. Recommendations for Bariatric Surgery Added in 2016

<table>
<thead>
<tr>
<th>No.</th>
<th>Recommendation</th>
<th>GOE</th>
<th>BEL</th>
</tr>
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<tbody>
<tr>
<td>35</td>
<td>Patients with obesity (BMI ≥30 kg/m²) and diabetes who have failed to achieve targeted clinical outcomes following treatment with lifestyle therapy and weight-loss medications may be considered for bariatric surgery, preferably Roux-en-Y gastric bypass, sleeve gastrectomy, or biliopancreatic diversion.</td>
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<tr>
<td>121</td>
<td>“Patients with a BMI of ≥35 kg/m² and 1 or more severe obesity-related complications, including type 2 diabetes, hypertension, obstructive sleep apnea, obesity-hypoventilation syndrome, Pickwickian syndrome, nonalcoholic fatty liver disease or nonalcoholic steatohepatitis, pseudotumor cerebri, gastroesophageal reflux disease, asthma, venous stasis disease, severe urinary incontinence, debilitating arthritis, or considerably impaired quality of life may also be considered for a bariatric surgery procedure. Patients with BMI of 30 to 34.9 kg/m² with diabetes or metabolic syndrome may also be considered for a bariatric procedure, although current evidence is limited by the number of patients studied and lack of long-term data demonstrating net benefit. • BMI ≥35 kg/m² and therapeutic target of weight control and improved biochemical markers of CVD risk.”</td>
<td>A</td>
<td>1</td>
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<tr>
<td></td>
<td>“BMI ≥30 kg/m² and therapeutic target of weight control and improved biochemical markers of CVD risk.”</td>
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<td>2</td>
</tr>
<tr>
<td></td>
<td>“BMI ≥30 kg/m² and therapeutic target of glycemic control in type 2 diabetes and improved biochemical markers of CVD risk.”</td>
<td>C</td>
<td>3</td>
</tr>
<tr>
<td>122</td>
<td>“Independent of BMI criteria, there is insufficient evidence for recommending a bariatric surgical procedure specifically for glycemic control alone, lipid lowering alone, or CVD risk reduction alone.”</td>
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</tr>
<tr>
<td>62</td>
<td>“Roux-en-Y gastric bypass should be considered as the bariatric surgery procedure of choice for patients with obesity and moderate to severe gastroesophageal reflux symptoms, hiatal hernia, esophagitis, or Barrett’s esophagus.”</td>
<td>Int</td>
<td>Int</td>
</tr>
<tr>
<td></td>
<td>“Intragastric balloon for weight loss may increase gastroesophageal reflux symptoms and should not be used for weight loss in patients with established gastroesophageal reflux.”</td>
<td></td>
<td>Strong</td>
</tr>
</tbody>
</table>


a Downgraded due to evidence gaps.

Joint guidelines on support for bariatric surgery patients were published by AACE, the Obesity Society, and American Society for Metabolic and Bariatric Surgery (ASMBS) in 2013. Recommendations on the following questions are summarized below.

“Which patients should be offered bariatric surgery?”
- “Patients with a BMI ≥40 kg/m² without coexisting medical problems and for whom bariatric surgery would not be associated with excessive risk should be eligible for 1 of the procedures.”
- “Patients with BMI ≥35 kg/m² and 1 or more severe obesity-related comorbidities…”
- “Patients with BMI of 30-34.9 kg/m² with diabetes or metabolic syndrome may also be offered a bariatric procedure although current evidence is limited by the number of subjects studied and lack of long-term data demonstrating net benefit.”
- “There is insufficient evidence for recommending a bariatric surgical procedure specifically for glycemic control alone, lipid lowering alone, or cardiovascular disease risk reduction alone, independent of BMI criteria.”

“Which bariatric surgical procedure should be offered?”
• “The best choice for any bariatric procedure (type of procedure and type of approach) depends on the individualized goals of therapy (e.g., weight loss and/or metabolic [glycemic] control), available local-regional expertise (surgeon and institution), patient preferences, and personalized risk stratification…. At this time, there is still insufficient evidence to generalize in favor of one bariatric surgical procedure for the severely obese population.”

Smoking Cessation
In 2013, the American Association of Clinical Endocrinologists, The Obesity Society, and American Society for Metabolic and Bariatric Surgery cosponsored clinical practice guidelines for the perioperative nutritional, metabolic, and nonsurgical support of the bariatric surgery patient. There are 74 recommendations. The following recommendation was developed addressing the issue of smoking cessation prior to bariatric surgery:

• Recommendation 20: “Tobacco use should be avoided at all times by all patients. In particular, patients who smoke cigarettes should stop, preferably at least 6 weeks before bariatric surgery (Grade A; BEL 2, upgraded by consensus). Also, tobacco use should be avoided after bariatric surgery given the increased risk for of poor wound healing, anastomotic ulcer, and overall impaired health (Grade A; BEL 1).”

American College of Cardiology et al
In 2013, the American College of Cardiology, American Heart Association, and the Obesity Society published joint guidelines on the management of obesity and overweight in adults.140 The guidelines made the following recommendations related to bariatric surgery:

• “Advise adults with a BMI ≥40kg/m² or BMI ≥35 kg/m² with obesity-related comorbid conditions who are motivated to lose weight and who have not responded to behavioral treatment with or without pharmacotherapy with sufficient weight loss to achieve targeted health outcome goals that bariatric surgery may be an appropriate option to improve health and offer referral to an experienced bariatric surgeon for consultation and evaluation. NHLBI Grade A (Strong); AHA/ACC COR [class of recommendation]: IIa; AHA/ACC LOE [level of evidence]: A”
• “For individuals with a BMI <35 kg/m², there is insufficient evidence to recommend for or against undergoing bariatric surgical procedures. NHLBI Grade N (No Recommendation)”

American Society for Metabolic and Bariatric Surgery
Intragastric Balloon Therapy
In 2016, ASMBS published a position statement on intragastric balloon therapy (the statement was also endorsed by the Society of American Gastrointestinal and Endoscopic Surgeons).141 The statement did not include specific recommendations for or against using these devices. A summary of key recommendations is as follows:

• There is level 1 data from RCTs [randomized controlled trials] on the “efficacy [and] safety of intragastric balloon therapy for obesity … [and] lower-level evidence [suggesting] that weight loss can be maintained … for some finite time into the future.”
• It is difficult to separate the effect from the intragastric “balloon alone from those of supervised diet and lifestyle changes…” This has been addressed in recent FDA [Food and Drug Administration] pivotal trials. “In general, any obesity treatment, including intragastric balloon therapy, would benefit from a multidisciplinary team…”
• “…serious complications are rare. Early postoperative tolerance challenges … can be managed with pharmacotherapy in the majority of patients…”

Sleeve Gastrectomy
In 2012, ASMBS published a position statement on sleeve gastrectomy.142 This updated statement provided the following conclusions:

“Substantial comparative and long-term data have now been published in the peer-reviewed studies demonstrating durable weight loss, improved medical co-morbidities, long-term patient satisfaction, and improved quality of life after SG [sleeve gastrectomy].”
The ASMBS therefore recognizes SG as an acceptable option as a primary bariatric procedure and as a first-stage procedure in high-risk patients as part of a planned staged approach.

From the current published data, SG has a risk/benefit profile that lies between LAGB [laparoscopic adjustable gastric banding] and the laparoscopic RYGB [Roux-en-Y gastric bypass]. As with any bariatric procedure, long-term weight regain can occur and, in the case of SG, this could be managed effectively with reinvention. Informed consent for SG used as a primary procedure should be consistent with consent provided for other bariatric procedures and should include the risk of long-term weight gain.

Surgeons performing SG are encouraged to continue to prospectively collect and report outcome data in the peer-reviewed scientific literature.”

Society of American Gastrointestinal and Endoscopic Surgeons
In 2013, the Society of American Gastrointestinal and Endoscopic Surgeons issued evidence-based guidelines on the management of a hiatal hernia, which included a recommendation about the repair of hiatal hernias incidentally detected at the time of bariatric surgery.130 These guidelines stated: “During operations for Roux-en-Y gastric bypass, sleeve gastrectomy and the placement of adjustable gastric bands, all detected hiatal hernias should be repaired” (moderate quality evidence, weak recommendation).

Guidelines for Children and Adolescents
Childerhose et al (2017) conducted a systematic review of adolescent bariatric surgery recommendation documents published in the United States and provided recommendations based on their review.143 The literature search was conducted from 1999 through 2013 and identified 16 recommendations for inclusion: 10 clinical practice guidelines, 4 position statements, and 2 consensus statements. Fifteen of the 16 publications recommended bariatric surgery for adolescents. The main reasons for recommending bariatric surgery for adolescents included: (1) surgery is effective in producing short- and long-term weight loss; (2) surgery is appropriate when the patient does not respond to behavioral or medical interventions; (3) surgery can improve long-term health and/or emotional problems. Body mass index thresholds ranged from 35 kg/m² or more to 50 kg/m² or more, with lower thresholds usually requiring the presence of at least 1 serious comorbidity. The minimum age was specified in 10 publications, with most using physiologic maturity (Tanner stage IV and/or 95% of adult height based on bone age, corresponding to ≥13 years for females and to ≥15 years for males) rather than years.

American Society for Metabolic and Bariatric Surgery
In 2012, ASMBS best practice guidelines found that current evidence was insufficient to discriminate among specific bariatric procedures, but allowed that there was an increasing body of data showing safety and efficacy of Roux-en-Y gastric bypass and adjustable gastric band for the pediatric population.144 Bariatric surgery was recommended for pediatric patients with morbid obesity and the following comorbidities:

Strong indications:
- Type 2 diabetes
- Moderate or severe obstructive sleep apnea (apnea-hypopnea index >15)
- Nonalcoholic steatohepatitis
- Pseudotumor cerebri

Less strong indications:
- Cardiovascular disease
- Metabolic syndrome
The guidelines stated that depression and eating disorders should not be considered exclusion criteria for bariatric surgery. The guidelines also noted that depression should be monitored following the procedure and that eating disorders should be treated and the patient stabilized before the procedure.

**European Society for Gastroenterology, Hepatology and Nutrition et al**

A joint position paper published by the European Society for Gastroenterology, Hepatology and Nutrition and the North American Society for Gastroenterology, Hepatology and Nutrition in 2015 made the following recommendations on indications for bariatric surgery in adolescents:

- **“BMI > 40 kg/m² with severe comorbidities**
  - Type 2 diabetes mellitus
  - Moderate-to-severe sleep apnea
  - Pseudotumor cerebri
  - NASH (nonalcoholic steatohepatitis) with advanced fibrosis (ISHAK score > 1)

- **BMI >50 kg/m² with mild comorbidities**
  - Hypertension
  - Dyslipidemia
  - Mild obstructive sleep apnea
  - Chronic venous insufficiency
  - Panniculitis
  - Urinary incontinence
  - Impairment in activities of daily living
  - NASH
  - Gastroesophageal reflux disease
  - Severe psychological distress
  - Arthropathies related to weight.”

- **Additional criteria included:**
  - “Have attained 95% of adult stature
  - Have failed to attain a healthy weight with previously organized behavioral/medical treatments
  - Demonstrate commitment to psychological evaluation perioperatively
  - Avoid pregnancy for 1 year after surgery...
  - Have decisional capacity and will provide informed assent/consent, as age appropriate.”

**Endocrine Society**

The Endocrine Society published recommendations on the prevention and treatment of pediatric obesity in 2008. In 2017, the Society sponsored an update of these guidelines by the Pediatric Endocrine Society and the European Society of Endocrinology. These guidelines recommended the following:

“**We suggest that bariatric surgery be considered only under the following conditions:**

1. The child has attained Tanner 4 or 5 pubertal development and final or near-final adult height.
2. The child has a BMI > 40 kg/m² or has BMI above 35 kg/m² and significant, extreme comorbidities.
3. Extreme obesity and comorbidities persist, despite compliance with a formal program of lifestyle modification, with or without a trial of pharmacotherapy.
4. Psychological evaluation confirms the stability and competence of the family unit.
5. There is access to an experienced surgeon in a pediatric bariatric surgery center of excellence that provides the necessary infrastructure for patient care, including a team capable of long-term follow-up of the metabolic and psychosocial needs of the patient and family.
6. The patient demonstrates the ability to adhere to the principles of healthy dietary and activity habits.

We recommend against bariatric surgery for preadolescent children, for pregnant or breastfeeding adolescents (and those planning to become pregnant within 2 yr of surgery) and in
any patient who has not mastered the principles of healthy dietary and activity habits and/or has an unresolved substance abuse, eating disorder, or untreated psychiatric disorder.”

**Institute for Clinical Systems Improvement**

In 2013, Institute for Clinical Systems Improvement published guidelines on the prevention and management of obesity in children and adolescents. The guidelines stated that there was limited long-term efficacy and safety data on bariatric surgery for the pediatric population, and that bariatric surgery should only be considered under the following conditions:

- “The child has a BMI > 40 kg/m² or has BMI above 35 kg/m² with a significant, severe comorbidity such as type 2 diabetes mellitus, obstructive sleep apnea, or pseudotumor cerebri.”
- “The child has attained Tanner 4 or 5 pubertal development or has a bone age ≥13 years in girls or ≥15 years in boys.”
- “Failure of ≥6 months of organized attempts at weight management,...”
- “The adolescent should have decisional capacity and also demonstrate commitment to comprehensive medical and psychological evaluation before and after surgery.”
- “A supportive family environment....”

**U.S. Preventive Services Task Force Recommendations**

Not applicable.

**Medicare National Coverage**

The Centers for Medicare & Medicaid Services have published a national coverage decision on bariatric surgery. The Centers determined that:

“...the evidence is adequate to conclude that open and laparoscopic Roux-en-Y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB), and open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS), are reasonable and necessary for Medicare beneficiaries who have a body mass index (BMI) ≥ 35, have at least one co-morbidity related to obesity, and have been previously unsuccessful with medical treatment for obesity.”

**Ongoing and Unpublished Clinical Trials**

Some currently unpublished trials that might influence this review are listed in Table 16.

### Table 16. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<td>NCT02741674</td>
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<td>NCT02881684</td>
<td>Weight Reduction by Aspiration Therapy in Asian Patients with Morbid Obesity</td>
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<td>NCT03102697</td>
<td>Optimization and Follow-Up of the Consecutive Use of Two Intra gastric Balloons in the Treatment of Obesity</td>
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<td>NCT01766037</td>
<td>Pivotal Aspiration Therapy with Adjusted Lifestyle Therapy Study</td>
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<td>Jun 2019</td>
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<tr>
<td>NCT02142257</td>
<td>Gastric Bypass Procedure and AspireAssist Aspiration Therapy System for the Treatment of Morbid Obesity, Observational Study over 5 Years</td>
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<tr>
<td>NCT02792166</td>
<td>Single Anastomosis Duodeno-ileal Bypass with Sleeve Gastrectomy (SADI-S): a Prospective Cohort Study</td>
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<td>NCT02779322</td>
<td>Laparoscopic Roux-en-Y Gastric Bypass Versus Single Anastomosis Gastric Bypass (MGB vs LG BP)</td>
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<td>Laparoscopic Single Anastomosis Duodenal-Jejunal Bypass with Sleeve Gastrectomy vs Laparoscopic Duodenal Switch (DS vs SADI)</td>
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<td>Apr 2026</td>
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</tbody>
</table>

NCT: national clinical trial.
a Denotes industry-sponsored or cosponsored trial.

References

51. Skogar ML, Sundbom M. Duodenal switch is superior to gastric bypass in patients with superobesity when evaluated with the Bariatric Analysis and Reporting Outcome System (BAROS). Obes Surg. Sep 2017;27(9):2308-2316. PMID 28439748


89. Noren E, Forssell H. Aspiration therapy for obesity; a safe and effective treatment. BMC Obes. Dec 2016;3:56. PMID 28035287


**Documentation for Clinical Review**

Please provide the following documentation (if/when requested):

**Bariatric Surgery in Adults with Morbid Obesity:**

- History and physical and/or consultation notes including prior weight loss attempts and responses, and comorbidities:
  - Co-morbidities, including, but not limited to: (when BMI is greater than or equal to 35.0 kg/m² and less than 40.0 kg/m²)
    - If diagnosed with coronary artery disease: Submit documentation from cardiologist that includes all previous and current treatments, as well as, member's current status
If diagnosed with diabetes: Submit documentation from primary care provider or endocrinologist that includes all previous and current treatments, as well as, type of diabetes

If diagnosed with hypertension: Submit documentation from primary care provider that includes all previous and current treatments, as well as, member’s current status

If diagnosed with obstructive sleep apnea: Submit official sleep study report interpreted by a sleep disorders specialist MD or Doctor of Osteopathic (DO) medicine and documentation of all conservative therapies attempted with duration and outcomes

If diagnosed with osteoarthritis: Submit documentation from primary care provider that includes radiographic reports

If diagnosed with hyperlipidemia: Submit documentation from primary care provider/cardiologist that includes all previous and current treatments

If diagnosed with GERD: Submit documentation from primary care provider or gastroenterologist that includes all previous and current treatments, as well as, any endoscopic findings

- Description of non-surgical weight-reduction program, initial weight, end weight, duration (start and end dates)
- Time lapse between the initial bariatric consultation and date of surgery (recommended 3 months)
- Documented failure of weight reduction to a BMI less than 35 kg/m² by conservative measures for 3 consecutive months in the past 12 months prior to consultation with the bariatric surgeon, and these attempts should be reviewed by the practitioner prior to seeking approval for the surgical procedure
- Medical doctor (MD) order for surgery that includes current height, weight, and body mass index (BMI), surgery requested and recommendation
- Documented educational counseling/class
- Completed and signed Bariatric Surgery Decision Aid by the patient
- Completed and signed CollaboRATE survey by the patient
- Signed Psychosocial-behavioral checklist
- Signed Pre-operative checklist

Revision and Repeat Bariatric Surgical Requests:
- History and physical and/or consultation notes including: prior surgery and complications (if applicable), indication for surgery, and treatment plan
- Post-surgical weight loss history (including pre- and post-surgical BMI), nutrition and exercise compliance
- Operative report(s) (if applicable)
- Diagnostic radiology, endoscopy, or contrast study reports (if applicable)

Bariatric Surgery in Adolescents:
- History and physical and/or consultation notes including: the same weight-based criteria used for adults
- Documentation of psychological counseling
- Documentation of informed consent
- Documentation that any device used for bariatric surgery is in accordance with the FDA-approved indication for use

Concomitant Hiatal Hemia Repair:
- Documentation of preoperatively-diagnosed hiatal hemia with indications for surgical repair
This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

**Coding**

The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

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<td>Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only</td>
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<td>Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components</td>
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<td>Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption</td>
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<td>Revision of gastro-jejunal anastomosis (gastro-jejunoscopy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy</td>
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**Policy History**

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

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<th>Effective Date</th>
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### Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

### Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.
Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.