Medical Policy

Bariatric Surgery	
MEDICAL POLICY NUMBER	Med_Clin_Ops-011
CURRENT VERSION EFFECTIVE DATE	January 1, 2024
APPLICABLE PRODUCT AND MARKET	*Individual Family Plan:* All Plans *Small Group*: All Plans *Medicare Advantage:* All Plans

Brand New Day/Central Health Medicare Plan develops policies and makes coverage determinations using credible scientific evidence including but not limited to MCG™ Health Guidelines, the ASAM Criteria™, and other third party sources, such as peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and expert opinion as relevant to supplement those sources. Brand New Day/Central Health Medicare Plan Policies, MCG™ Guidelines, and the ASAM Criteria™ are not intended to be used without the independent clinical judgment of a qualified health care provider considering the individual circumstances of each member's case. The treating health care providers are solely responsible for diagnosis, treatment, and medical advice. Members may contact Brand New Day/Central Health Medicare Plan Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Brand New Day/ Central Health Medicare Plan policy may contact the Health Plan. Brand New Day/Central Health Medicare Plan policies and practices are compliant with federal and state requirements, including mental health parity laws.

If there is a difference between this policy and the member specific plan document, the member benefit plan document will govern. For Medicare Advantage members, Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), govern. Refer to the CMS website at http://www.cms.gov for additional information.

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PURPOSE

The purpose of this policy is to establish the clinical review criteria that support the determination of medical necessity of bariatric surgery.

POLICY

I. CRITERIA FOR INITIAL BARIATRIC SURGERY:

Approval for surgical intervention is based on member meeting **ALL** of the following criteria:

1. Patient must be 18 years of age or older.
2. A participating facility and a participating board-certified bariatric surgeon must provide evaluation and treatment.
3. Patient must have a body mass index (BMI) of ≥ 40 or BMI ≥ 35 with at least **one or more** of the following co-morbid conditions. (For patients who have fluctuating weights, the periods of low weight are disregarded when duration is determined.)
   a) Clinically significant obstructive sleep apnea.
   b) Coronary heart disease, with objective documentation (by exercise stress test, radionuclide stress test, pharmacologic stress test, stress echocardiography, CT angiography, coronary angiography, heart failure or prior myocardial infarction).

c) Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite concurrent use of 3 anti-hypertensive agents of different classes).

d) Type 2 diabetes mellitus.

e) Nonalcoholic steatohepatitis (NASH).

4. Documentation has been submitted by the requesting bariatric surgeon indicating the severity of the comorbid conditions.
5. The patient has been unsuccessful with medical treatment of obesity. A patient will be deemed to have been unsuccessful with medical treatment of obesity if **ALL** of the following minimal requirements are met per documentation in the medical record:
   a) Attempts at medically supervised conservative weight loss measures within the last six months (consecutively) prior to the request have not been effective.
   b) The patient has made a diligent effort to achieve healthy body weight with such efforts described in the medical record and certified by the operating surgeon or primary care provider.
   c) The patient has failed to maintain a healthy weight despite adequate participation in a structured dietary program overseen by a nutrition professional.
   d) Documentation has been submitted that includes **ALL** of the following:
      i) A summary of historical attempts at weight loss (for example, failed attempts).
      ii) Details of present exercise program participation (for example, physical activity, workout plan). Documentation of the physician's opinion regarding the patient's ability to exercise will be taken into consideration during review .
      iii) Details of nutrition program (for example, calorie intake, meal plan, diet followed).
      iv) That conservative measures have been refractory for at least six (6) months.
6. The patient has undergone a **multi-disciplinary preparatory regimen** as part of pre-operative evaluation and intervention within six (6) months of the prior authorization, and the results of this multi-disciplinary approach are submitted by the requesting bariatric surgeon. This multi-disciplinary approach includes (at minimum):
   a) Evaluation by a **medical subspecialist** or **primary care provider** within six (6) weeks prior to the date of the prior authorization request such that:
      i) A complete medical history has been obtained.
      ii) All medical causes of obesity have been considered.
      iii) Co-morbidities that may complicate surgery have been identified and addressed.
   b) Patient has undergone a nutrition consultation by a **nutrition professional** which includes nutritional assessment, diet education regarding postoperative eating behaviors, and preoperative weight loss efforts.
   c) Patient has completed an evaluation by a **behavioral health professional** within

the three (3) months preceding the request for surgery. This evaluation should document:

i) The absence of significant psychopathology that would hinder the ability of an individual to understand the procedure and comply with medical/surgical recommendations.

ii) The absence of any behavioral health comorbidity that could contribute to weight mismanagement and/or a diagnosed eating disorder.

iii) The absence of substance use disorder (including alcohol and other chemical dependencies).

iv) The patient's willingness and ability to comply with preoperative and postoperative treatment plans.

7. Documentation in the medical record of tobacco status indicating the following:
   a) The individual is a non-tobacco user.
   b) The individual has been tobacco-free for a minimum of eight (8) weeks prior to the date of the prior authorization request.
8. For patients with a substance abuse history, clinical documentation must be submitted that the patient has been substance-free for more than one (1) year or must be in a controlled treatment program and stabilized.
9. The patient does not have an absolute contraindication to bariatric surgery, including **ANY** of the following:
   a) Prohibitive perioperative risk of cardiac complications due to cardiac ischemia or myocardial dysfunction.
   b) Severe chronic obstructive airway disease or respiratory dysfunction.
   c) Non-compliance with medical treatment of obesity or treatment of other chronic medical condition.
   d) Psychological/psychiatric conditions

      Note: depression related to obesity is not typically considered a contraindication for bariatric surgery.

      i) Schizophrenia, borderline personality disorder, suicidal ideation, severe or recurrent depression, or bipolar affective disorders with difficult-to-control manifestations (for example, history of recurrent lapses in control or recurrent failure to comply with management regimen).

      ii) Mental retardation that prevents personally provided informed consent or the ability to understand and comply with a reasonable pre- and postoperative regimen.

      iii) Any other psychological/psychiatric disorder that, in the opinion of a psychologist/psychiatrist, imparts a significant risk of psychological/psychiatric decompensation or interference with the long-term postoperative management.

      iv) History of significant eating disorders, including anorexia nervosa, bulimia, pica

(sand, clay, or other abnormal substance), and/or Binge Eating Disorder

e) Severe hiatal hernia/gastroesophageal reflux (for purely restrictive procedures such as LAGB).

f) Autoimmune and rheumatological disorders (including inflammatory bowel diseases and vasculitides) that will be exacerbated by the presence of intra-abdominal foreign bodies (for LAGB procedure).

g) Hepatic disease with prior documented inflammation, portal hypertension, or ascites.

10. **Documentation**

The surgeon must submit documentation that the patient has demonstrated understanding of **ALL** of the following:

- Potential risks and benefits of weight loss surgery.
- Need for a least three follow-up visits with the bariatric surgery team within the first year.
- Need for post-surgical lifestyle modification, exercise, and dietary changes reinforced by counseling and/or support groups.
- Lifetime postoperative care for dietary issues (including vitamin, mineral and nutritional supplementation).
- Lifelong follow-up.
- Changes to skin and tissue after weight loss.

II. CRITERIA FOR BARIATRIC SURGERY REVISIONS

Members may be eligible for bariatric surgical revision procedures when coverage for bariatric surgery is available under the individual's current plan and when procedures are considered medically necessary.

Bariatric surgical revision procedures are considered medically necessary if:

1. Revision is **NOT** being performed to modify pouch dilatation or stretching related to dietary or behavior modification noncompliance; **AND** the following occur:
   a) Complications related to the surgical procedure including but not limited to malabsorption, obstruction, or staple disruption.
   b) Revision is required for a documented surgical complication of a covered bariatric procedure (for example, anastomotic strictures, band erosion or slippage, gastrogastric fistula, GI bleeding, leak, marginal ulcer, obstruction, stomal stenosis).
   c) Band removal, replacement or conversion to another bariatric procedure is required due to conditions that cannot be corrected with band adjustment or manipulation (for example, band erosion or slippage, intractable nausea/vomiting/ reflux).
2. Requests for bariatric surgical revisions for failure of weight loss after primary bariatric surgery must meet the same requirements as initial bariatric surgical procedures.

III. COVERAGE

Covered Procedures:
Prior authorization **is required** for gastrointestinal surgery for obesity when one of the following procedures is requested. The following procedures **may be covered** under this policy and are listed here:

1. Open and laparoscopic Roux-en-Y Gastric Bypass (RYGBP)
    - All Plans
2. Open and laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS)
    - All Plans
3. Sleeve gastrectomy (Open and Laparoscopic)
    - Plans in Alabama, Colorado, Florida, Nebraska**,** North Carolina, Oklahoma, South Carolina, Tennessee
    - **EXCEPTION: Arizona – ONLY Laparoscopic** sleeve gastrectomy is covered**.** Open Sleeve gastrectomy **IS NOT** Covered for any Arizona IFP plans.
4. Laparoscopic Adjustable Gastric Banding (LAGB)
    - **EXCEPTION:** ONLY IFP plans in Arizona cover this procedure

Coverage Limitations:

The following procedures are **NOT** covered under this policy:

NOTE: This list should not be considered exhaustive of non-covered procedures – consult and/or validate with Brand New Day/Central Health Medicare Plan, for any procedures that do not meet any of the categories above, under the covered and coverage limitations sections.

1. Laparoscopic Adjustable Gastric Banding (LAGB)
    - (**EXCEPTION:** All plans **EXCEPT** Arizona plans. LAGB is covered **ONLY** in Arizona – see above)
2. Vertical-banded gastroplasty (Open and Laparoscopic)
3. Endoscopic Sleeve Gastroplasty
4. Open adjustable gastric banding
5. Gastric balloon
6. Laparoscopic gastric plication
7. Mini gastric bypass
8. Drainage device
9. Endoscopic gastrointestinal bypass device (EGIBD)

10. Restorative obesity surgery, endoluminal (ROSE)
11. Transoral gastroplasty
12. Transoral outlet reduction
13. Single anastomosis duodeno-ileal bypass with sleeve gastrectomy
14. Vagus/vagal nerve block
15. Bariatric arterial embolization
16. Jejunoileal bypass
17. Experimental, investigational, or newly approved procedures or medical devices used in the treatment of obesity.

BACKGROUND

Bariatric surgery, also known as weight loss surgery, is performed on the gastro-intestinal (GI) tract of obese persons to alter the digestive process and induce weight loss. The mechanisms of action are considerably more complex, involving neuroendocrine signaling and hormone alteration to appetite and satiety centers in the central nervous system. Bariatric surgical techniques may be classified as restrictive, malabsorptive or a combination of both. Restrictive procedures reduce the stomach size, thus decreasing the amount of food the stomach can hold. Malabsorptive procedures limit the amount of nutrients and calories that the body can absorb.

Most procedures may be done using a laparoscopic or an open approach.

A subset of specific surgical approaches and procedures can be found under the Definition section, below.

DEFINITIONS

1. **Authorization:** A decision by Brand New Day/Central Health Medicare Plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary or meets other member contract terms. Sometimes called prior authorization, prior approval or precertification. Brand New Day/Central Health Medicare Plan requires preauthorization for certain services before a member receives them, except in an emergency. Authorization is not a promise that Brand New Day/Central Health Medicare Plan will cover the cost.
2. **Behavioral Health Professional** is a provider trained in behavioral issues and behavioral therapy and can be one of the following:
    a) Psychiatrists (MD or DO)
    b) Psychologists
    c) Psychiatric nurse practitioners
    d) Social Worker
    e) Mental Health Professionals
3. **Body Mass Index** (BMI) is defined as the member's body mass divided by the square of his or her height.
    a) Obesity (Class I) is defined as a body mass index (BMI) ≥ (equal to or greater than) 30-34.9 kg/m^2

b) Obesity (Class II) is defined as BMI 35-39.9 kg/m^2
c) Extreme Obesity (Class III) (also known as Morbid Obesity) is defined as BMI ≥ 40 kg/m^2

4. **Clinically significant weight loss** is weight loss that results in reduction of medical comorbidities.
5. **Comorbidity** is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases. Examples of **comorbid conditions** may include, but are not limited to:
   a) Type II diabetes mellitus (by American Diabetes Association diagnostic criteria).
   b) Refractory hypertension (defined as blood pressure of 140 mmHg systolic and/or 90 mmHg diastolic despite medical treatment with maximal doses of three antihypertensive medications).
   c) Refractory hyperlipidemia (acceptable levels of lipids unachievable with diet and maximum doses of lipid lowering medications).
   d) Obesity-induced cardiomyopathy.
   e) Clinically significant obstructive sleep apnea.
   f) Obesity-related hypoventilation.
   g) Pseudotumor cerebri (documented idiopathic intracerebral hypertension).
   h) Severe arthropathy of spine and/or weight-bearing joints (when obesity prohibits appropriate surgical management of joint dysfunction treatable but for the obesity).
   i) Hepatic steatosis without prior evidence of active inflammation.
5. **Nutrition Professional** is a provider trained in nutrition and can be one of the following:
   a) Physician (MD or DO)
   b) Registered dietician (RD)
   c) Board certified specialist in renal nutrition (CSR)
   d) Fellow of the American Dietetic Association (FADA)
6. **Robotic-assisted surgeries** are minimally invasive procedures performed from a computerized workstation. The surgeon sits at a console with a three-dimensional video monitor as well as hand and/or foot controls. A variety of surgical instruments are mounted on robotic arms, allowing the surgeon range of motion and flexibility as he or she performs the procedure. Robotic devices are designed to access surgical sites through smaller incisions or ports using an endoscope. The primary difference between robotic and conventional laparoscopic surgery is that the instruments are controlled indirectly via a computer interface rather than manually by a surgeon.
7. **Procedures: Examples/Subset of Bariatric Surgery Procedures:**
   a) **Roux-en-Y gastric bypass (RYGB) (open or laparoscopic)** is the most common and successful malabsorptive surgery and is generally known as gastric bypass. In this procedure, a small stomach pouch is created to restrict food intake. The rest of the stomach is bypassed via a Y-shaped segment of the small intestine, which reduces the amount of calories and nutrients the body absorbs. Long-limb RYGB is similar to standard RYGB, except that the limb through which food passes is longer and is often used to treat super obese individuals.

   b) **Biliopancreatic diversion (BPD)** consists of a partial gastrectomy (resection of the stomach) and gastroileostomy (surgical connection of the stomach to the ileum, the last section of small intestine). It allows for relatively normal meal size, since the most proximal areas of the small intestine are bypassed and substantial malabsorption occurs. It is less frequently used than other types of procedures because of the high risk

for nutritional deficiencies.

c) **Biliopancreatic diversion (BPD) with duodenal switch (DS)** while similar to the above procedure, leaves a larger portion of the stomach intact, including the pyloric valve that regulates the release of stomach contents into the small intestine. It also keeps a small portion of the duodenum in the digestive pathway.

d) **Adjustable gastric banding (LAGB) (e.g., Lap-Band, Realize) (open or laparoscopic)** involves the placement of a hollow band around the upper end of the stomach, creating a small pouch and a narrow passage into the larger remainder of the stomach. The band is inflated with a saline solution, which can be increased or decreased over time to alter the size of the passage. **(With respect to open adjustable gastric banding, refer to Coverage Limitations section)**

e) **Sleeve gastrectomy (open or laparoscopic),** also called **vertical sleeve gastrectomy**, involves the removal of the greater curvature of the stomach and approximately 80 percent of the stomach volume. While pyloric sphincter and stomach functions are preserved, the remaining stomach resembles a slender curved tube. Sleeve gastrectomy was originally the first step of a more extensive two-step bariatric surgery (i.e., biliopancreatic diversion with duodenal switch) that had been typically reserved for severely obese individuals (BMI > or = 50 kg/m2) or high-risk individuals with multiple comorbidities but may also be performed as a single-stage primary procedure for potential bariatric surgery candidates. **(With respect to open sleeve gastrectomy, refer to Coverage Limitations section)**

f) **Laparoscopic gastric plication**, also called **laparoscopic greater curvature plication (LGCP) with or without gastric banding**, is the creation of a smaller stomach pouch by folding and sewing the stomach. It may also be performed in conjunction with gastric banding, which purportedly increases early weight loss and decreases the need for band adjustments. **(Refer to Coverage Limitations section)**

g) **Mini gastric bypass (MGB) (laparoscopic)** divides the stomach similar to a traditional gastric bypass, but instead of creating a Roux-en-Y connection, the jejunum is attached directly to the stomach. **(Refer to Coverage Limitations section)**

h) **Drainage device (ie, AspireAssist)** involves the endoscopic surgical insertion of a drainage tube in the stomach that connects to an externally accessible port that sits flush against abdominal skin. Approximately 20 – 30 minutes after eating each daily meal, the individual attaches external components which open the port valve. The stomach contents are drained, irrigated with water and drained again. **(Refer to Coverage Limitations section)**

i) **Endoscopic gastrointestinal bypass device (EGIBD)** is a removable barrier that extends from the upper segment of the GI tract (gastroesophageal junction or duodenum) to the jejunum. By lining the upper portion of the small intestine, it causes nutrient absorption to occur further along the GI tract. **(Refer to Coverage Limitations section)**

j) **Gastric Balloon**, also called **intragastric balloon**, involves the temporary endoscopic placement (most commonly, though other introduction techniques may also be used) of a silicone balloon or dual balloon system filled with air or saline solution (sterile salt water) into the stomach. The presence of the balloon conveys a sense of fullness and

restricts the stomach volume, thereby purportedly decreasing food intake. Intragastric balloons differ in their volume, duration in the stomach, adjustability, and means of insertion and removal. Examples of US Food and Drug Administration (FDA) approved intragastric balloons include, but may not be limited to, Orbera intragastric balloon system and ReShape integrated dual balloon system. The FDA approved Obalon balloon system allows an individual to swallow a capsule containing a balloon. A thin inflation catheter attached to the capsule remains externally accessible until the capsule dissolves, and balloon placement is verified radiographically. The catheter is used to inflate the balloon with a gas mixture and then disconnected from the balloon. **(Refer to Coverage Limitations section)**

k) **Restorative obesity surgery, endoluminal (ROSE) procedure** is suggested for the treatment of weight regain following gastric bypass surgery due to a gradual expansion of the gastric pouch. The stomach is accessed orally via an endoscope and reduced in size using an endoscopic closure device. **(Refer to Coverage Limitations section)**

l) **Transoral gastroplasty (TG)**, also referred to as **vertical sutured gastroplasty** or **endoluminal vertical gastroplasty**, is an incisionless procedure in which the stomach is purportedly restricted with staples or sutures by using endoscopic surgical tools guided through the mouth and esophagus. **(Refer to Coverage Limitations section)**

m) **Transoral outlet reduction (TORe)** is an endoscopic method of correcting a dilated gastrojejunostomy outlet after Roux-en-Y in individuals experiencing weight regain due to a relaxed gastric outlet. The enlarged gastric outlet reduces the sense of fullness and allows greater amounts of food ingestion. **(Refer to Coverage Limitations section)**

n) **Single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S),** also referred to as a **single loop duodenal switch (DS)** or **stomach intestinal pylorus sparing surgery (SIPS),** is a newer operation based on the biliopancreatic diversion with duodenal switch (BPD-DS), however the pylorus is able to be preserved and the reconstruction occurs in one loop, which purportedly reduces operating time and requires no mesentery opening. **(Refer to Coverage Limitations section)**

o) **Vagus/vagal nerve block, vagal blocking for obesity control (VBLOC [eg, Maestro])** also referred to as gastric pacing or vagal nerve stimulation involves laparoscopic placement of two leads (electrodes) in contact with vagal nerve trunks and a subcutaneously implanted neuromodulation device which is externally programmed to intermittently send electrical impulses via the implanted electrodes. The electrical impulses are purported to block vagus nerve signals in the abdominal region, inhibiting gastric motility and increasing satiety (feeling full). **(Refer to Coverage Limitations section)**

p) **Vertical banded gastroplasty (VBG) (open or laparoscopic)** involves removal of stomach tissue and the use of a band and staples to create a small stomach pouch. VBG has been largely replaced by other procedures deemed to be more successful regarding sustained weight loss and is therefore rarely performed. **(Refer to Coverage Limitations section)**

q) **Bariatric arterial embolization (BAE)**, or transarterial embolization of the left gastric artery, is a minimally invasive image-guided procedure that aims to directly modulate

the neurohormonal axes of hunger by altering the endocrine function of the gastric fundus. BAE uses targeted transvascular delivery of embolic microspheres or liquid embolics into the gastric arteries to purportedly alter endocrine production. The procedure also purports to indirectly affect acid production, gastric motility, and possibly absorption.

Note: Refer to Coverage Limitations Section for more information.

8. **Revisions/Bariatric Surgery Revision** (may be referred to as repeat or reoperation) Revision of a bariatric surgery procedure may be necessary due to insufficient weight loss, specific complications from the primary procedure, nutritional problems or other reasons. The revision performed depends on several factors, including the initial bariatric surgery performed and the type of complication that has occurred.
9. **Tobacco/Nicotine** products can result in nicotine addiction and health problems, including a negative effect on outcomes related to bariatric surgery. Products containing nicotine include, but are not limited to;
   a) Smoked tobacco (e.g., cigarettes, cigars, cigarillos, pipe tobacco);
   b) Smokeless tobacco (e.g., chewing tobacco, snuff);
   c) Electronic cigarettes (E-cigarettes); **AND**
   d) Nicotine patches.

CODING

The codes listed below are for reference purposes. This list does not imply whether the code is covered or not covered. The benefit document should be referenced for coverage determination. This list of applicable codes may not be all-inclusive.

43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, 43999.

**** Notes:**

1. Endoscopy is considered integral to the primary procedure and not separately reimbursable.
2. Robotic-assisted surgery is considered integral to the primary procedure and not separately reimbursable.

EVIDENCE BASED REFERENCES

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Long-term Outcomes of Laparoscopic Adjustable Gastric Banding Arch Surg. 2011 Jul;146(7):802-7. Jacques Himpens[1], Guy-Bernard Cadière, Michel Bazi, Michael Vouche, Benjamin Cadière, Giovanni Dapri PMID: **21422330** doi: 10.1001/archsurg.2011.45. Epub 2011 Mar 21. DOI: 10.1001/archsurg.2011.45
https://pubmed.ncbi.nlm.nih.gov/21422330/

UpToDate Review: Bariatric procedures for the management of severe obesity: Descriptions Author: Robert B Lim, MD, FACS, FASMBS Section Editor: Daniel Jones, MD Deputy Editor: Wenliang Chen, MD, PhD. Operations for weight loss include a combination of volume-restrictive, intestinal hormone alteration, and nutrient-malabsorptive procedures that affect satiety, absorption, and insulin sensitivity in conjunction with behavior modification to achieve and sustain weight loss. This topic will review the contemporary, investigational, revisional, and obsolete bariatric procedures offered to obese patients with a surgical indication. The indications are a body mass index (BMI) of greater than or equal to 40 kg/m2, a BMI of 35 to 39.9 kg/m2 with an obesity-related comorbidity (eg, diabetes, hypertension, gastroesophageal reflux disease, osteoarthritis, among many others), or a BMI of >30 kg/m2 with difficult-to-control type II diabetes mellitus or dysmetabolic syndrome X. Indications, preoperative preparation, postoperative management, complications, and outcomes of bariatric surgical procedures are described in the following topic

REGULATORY REFERENCS

Centers for Medicare and Medicaid Services (CMS) [web site]. National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (100.1).

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POLICY HISTORY

This policy has been approved by the approval body listed below or has received other necessary approval pursuant to Brand New Day/Central Health Medicare Plan's policies on clinical criteria and policy development.

Approval Body	Utilization Management Committee		
Version History	**Approval Date**	**Effective Date**	**Action**
V1	10-22-2018	12-22-2018	New Policy
V2	09-30-2019	09-30-2019	Annual review by UM Committee
V3	02-01-2020	02-01-2020	Updated to include appropriate 2020 markets
V4	05-18-2020	05-18-2020	Annual review, updated policy to clarify procedure coverage and coverage limitations in Arizona
V5	12-20-2020	12-20-2020	Small Group added as applicable product
V6	05-31-2021	05-31-2021	Annual review
V7	06-16-2022	06-16-2022	Annual review
V8	06-16-2022	03-01-2023	Adopted by MA UMC