Vagus Nerve Blocking Therapy for Treatment of Obesity

Policy Number: 7.01.150  Last Review: 4/2020

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will not provide coverage for Vagal Nerve Blocking Therapy for Treatment of Obesity. This is considered investigational.

When Policy Topic is covered
n/a

When Policy Topic is not covered
Intra-abdominal vagal nerve blocking therapy is considered investigational in all situations, including but not limited to the treatment of obesity.

Description of Procedure or Service

<table>
<thead>
<tr>
<th>Populations</th>
<th>Interventions</th>
<th>Comparators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals:</td>
<td>Interventions of interest are:</td>
<td>Comparators of interest are:</td>
<td>Relevant outcomes include:</td>
</tr>
<tr>
<td>With obesity</td>
<td>- Vagal nerve blocking therapy</td>
<td>- Conservative care ie diet, exercise</td>
<td>- Change in disease status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Pharmacologic therapy</td>
<td>- Morbid events</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Surgery</td>
<td>- Quality of life</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Treatment-related morbidity</td>
</tr>
</tbody>
</table>

Vagus nerve blocking therapy for obesity consists of an implantable device that delivers electrical stimulation to branches of the vagus nerve on the anterior abdominal wall. The intent is to intermittently block signals to the intra-abdominal vagus nerve to disrupt hunger sensations and induce feelings of satiety.

For individuals with obesity who receive vagus nerve blocking therapy, the evidence includes two sham-controlled randomized trials. The relevant outcomes are change in disease status, morbid events, quality of life, and treatment-related morbidity. The primary efficacy outcome (at least a 10% difference between groups at 12 months) was not met for either trial. In the first trial (EMPOWER), the observed difference in excess weight loss between groups at 12 months was
1%. In the more recent trial (ReCharge), the observed difference in excess weight loss between groups at 12 months was 8.5%; a post hoc analysis found this difference statistically significant, but the magnitude of change may not be viewed as clinically significant according to investigators’ original trial design decisions. Post hoc analyses of longer-term data have been published and are subject to various biases, including missing data and unblinding at 12 months. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Background**

**Obesity**
Obesity is a common condition in the United States. A large nationally representative survey conducted from 2009 to 2010 found that 36% of American adults aged 20 years and older were obese, defined as a body mass index (BMI) of 30 kg/m² or more.¹ Fifteen percent of these adults had a BMI of 35 kg/m² or more and 6% had a BMI of 40 kg/m² or more. Among 2- to 19-year-olds, 17% were obese, which is defined in this population as being at or above the 95% percentile in sex-specific BMI for corresponding age (based on the U.S. Centers for Disease Control and Prevention age growth charts).

Obesity is a major cause of premature death and is linked to serious illnesses including heart disease, type 2 diabetes, sleep apnea, osteoarthritis, and certain types of cancer. In a 2013 systematic review, being obese was associated with higher all-cause mortality and death from cardiovascular disease.² In that same year, the American Medical Association officially recognized obesity itself as a disease.

**Management and Treatment**
Weight loss (bariatric) surgery is a potential option for obese patients who have failed conservative treatments. Common procedures include gastric bypass surgery (open or laparoscopic approaches), sleeve gastrectomy, and laparoscopic adjustable gastric banding. Certain types of bariatric surgery have improved outcomes in select patients who choose that treatment. (Bariatric surgery is addressed in separate policy.)

Vagus nerve blocking therapy is another potential treatment option for obese patients. The vagus nerve consists of two long cranial nerves that extend from the brainstem to the viscera. The term *vagus* is Latin for wandering, and the vagus nerve winds through the abdomen and has branches that come into contact with the heart, lung, stomach, and other body parts. The vagus nerve plays a major role in autonomic and sympathetic nervous system functioning, including regulation of heartbeat and breathing. It is also involved in the regulation of the digestive system, although its exact role in controlling appetite and feelings of satiety is unknown. Vagus nerve blocking therapy involves intermittent blocking of signals to the intra-abdominal vagus nerve, with the intent of disrupting hunger sensations and inducing feelings of satiety.

In January 2015, the U.S. Food and Drug Administration (FDA) approved a medical device specifically designed to provide vagal nerve blocking therapy for
regulation of weight in obese patients. This device, the Maestro Rechargeable System, includes a neuroblocking pulse generator that is implanted subcutaneously on the thoracic sidewall and flexible leads approximately 47 cm in length that are placed on the abdominal anterior and posterior vagal nerve trunks. External components include a mobile charger, a transmit coil, a programmable microprocessor, and customized software. The system delivers high-frequency pulses of electrical current to vagus nerve trunks; therapy parameters and the treatment schedule can be customized by a clinician. Like other surgical interventions, there is the potential for adverse effects. In addition, there may be other unintended consequences of disrupting signals to a particular portion of the vagus nerve.

Stimulation of the vagus nerve via a device implanted within the carotid artery sheath has also been evaluated as a treatment for obesity and is addressed in a separate policy. Vagus nerve stimulation is approved by the FDA to treat epilepsy and depression, but not obesity.

**Outcomes**

To assess obesity treatments, a double-blind randomized controlled trial is optimal because these interventions require changes to patient behavior (ie, diet, exercise) that are subject to the placebo effect. Health outcomes such as mortality, cardiovascular events, and rates of type 2 diabetes would be optimal but are difficult to use as study endpoints due to the need for large sample size and long follow-up period. Cardiovascular risk factors, such as changes in blood pressure, glucose, and lipid levels, are good intermediate measures because they have been linked with these health outcomes and would require smaller sample sizes. Weight loss outcomes reported as an absolute change in weight or BMI, or as percent excess weight loss or percent BMI are acceptable intermediate outcome measures and are commonly used in obesity studies. Weight loss has been linked to improvements in cardiovascular risk factors. While no generally accepted threshold of percent excess weight loss is considered clinically significant, bariatric surgery trials generally define clinical success as at least 50% excess weight loss. The amount of weight loss is expected to be lower for other, less dramatic weight loss interventions.

Sham controls are useful for establishing the efficacy of intervention beyond the placebo effect and for controlling other nonspecific effects of interventions including disease natural history and regression to the mean. Because there are so many existing treatment options for weight loss, if sham-controlled weight loss intervention studies are positive, trials using an active comparator, such as medication or other types of surgery, are desirable.

**Regulatory Status**

In January 2015, the Maestro® Rechargeable System (EnteroMedics, St. Paul, MN) was approved by the FDA through the premarket approval process for use in adults ages 18 years and older who have a BMI of 40 to 45 kg/m² or a BMI of 35 to 39.9 kg/m² with 1 or more obesity-related conditions such as high blood pressure or high cholesterol and have failed at least 1 supervised weight
management program within the past 5 years. Implantable components are incompatible with magnetic resonance imaging. Additional contraindications to use of the device include conditions such as cirrhosis of the liver, portal hypertension, clinically significant hiatal hernia, and the presence of a previously implanted medical device. FDA product code: PIM.

**Rationale**
This evidence review was created in April 2015 and has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through January 26, 2019.

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the 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 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 technology, two domains are examined: the relevance, and 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.

**Vagus nerve Blocking therapy for obesity**

**Clinical Context and Test Purpose**
The purpose of vagal nerve blocking therapy for the treatment of obesity is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: does the use of vagal nerve blocking therapy for the treatment of obesity improve net health outcomes?

The following PICOTS were used to select literature to inform this review.
**Patients**
The relevant population of interest are patients with morbid obesity who have been unsuccessful with lifestyle management for weight reduction.

**Interventions**
The therapy being considered is vagal nerve blocking therapy for the treatment of obesity. Vagus nerve blocking therapy involves the intermittent blocking of signals to the intra-abdominal vagus nerve, with the intent of disrupting hunger sensations and inducing feelings of satiety.

**Comparators**
The following therapies and practices are currently being used to make decisions about the treatment of obesity; lifestyle interventions, specifically changes to diet and exercise, are the first-line treatment of obesity. These interventions can be enhanced by participation in a structured weight loss program and/or by psychological interventions such as cognitive-behavioral therapy. There are also prescription weight loss medications available, most notably orlistat (which blocks digestion and absorption of fat) and lorcaserin (which decreases appetite and promotes satiety). Weight loss medications have limited evidence of efficacy and there are adverse events (e.g., oily stool, nausea, dizziness) associated with their use. Weight loss (bariatric) surgery is a potential option for obese patients who have failed conservative treatments.

**Outcomes**
The general outcomes of interest are weight reduction and maintenance of weight reduction, disease status changes such as the development of medical complications of obesity, and treatment-related morbidity.

**Timing**
Patients with obesity who receive vagal nerve blocking therapy would require follow-up for 6-12 months to ascertain weight loss success and early device complications. Follow-up of maintenance of weight loss or obesity-associated conditions are life-long. Type 1 diabetes mellitus requires life-long medical monitoring of glycemic control and end-organ status.

**Setting**
Patients receive chronic intermittent intravenous insulin therapy in weekly outpatient treatment sessions.

**Study Selection Criteria**
Methodologically credible studies were selected using the following principles:

a. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
b. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
c. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
Studies with duplicative or overlapping populations were excluded.

**Randomized Controlled Trials.**
The published literature on vagus nerve blocking for obesity consists of two RCTs, both of which were industry-sponsored, multicenter, double-blind, and sham-controlled. Although both trials included a sham treatment group, protocols differed. In the 2012 EMPOWER trial, all participants had devices implanted and leads placed. However, external controllers were programmed differently such that if the controllers were worn for 10 hours a day, the total charge delivered was 3.9 coulombs (C) to patients in the treatment group and a negligible amount (0.0014 C), to the sham group. In the 2014 ReCharge trial, all participants had devices implanted, but no leads were placed in the sham group.

Trial characteristics and results are summarized in Tables 1 and 2, respectively.

**Table 1. Characteristics of RCTs Evaluating Vagus Nerve Blocking as Treatment of Morbid Obesity**

<table>
<thead>
<tr>
<th>Author; Study</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Participants</th>
<th>Interventions</th>
<th>Comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarr et al (2012)^3; EMPOWER</td>
<td>U.S., Australia</td>
<td>15</td>
<td>Nov 2005-Sep 2011</td>
<td>294</td>
<td>192 to active Maestro device plus 15 weight management counseling sessions</td>
<td>102 to inactive sham Maestro device plus 15 weight management counseling sessions</td>
</tr>
<tr>
<td>Ikramuddin et al (2014)^4; ReCharge</td>
<td>U.S., Australia</td>
<td>10</td>
<td>May 2011-Jun 2013</td>
<td>239</td>
<td>162 to active Maestro device plus 17 weight management counseling sessions</td>
<td>77 to inactive sham Maestro device plus 17 weight management counseling sessions</td>
</tr>
</tbody>
</table>

RCT: randomized controlled trial.

**Table 2. Results of RCTs Evaluating Vagus Nerve Blocking as Treatment of Morbid Obesity**

<table>
<thead>
<tr>
<th>Study</th>
<th>Mean Percent EWL</th>
<th>≥25% EWL</th>
<th>Serious Adverse Events, n/n (%) or %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarr et al (2012)^3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active</td>
<td>17</td>
<td>22</td>
<td>23/192 (12%)</td>
</tr>
<tr>
<td>Sham</td>
<td>16</td>
<td>25</td>
<td>12/102 (12%)</td>
</tr>
<tr>
<td>Diff (95% CI)</td>
<td>1 (NR)</td>
<td>-3 (NR)</td>
<td></td>
</tr>
<tr>
<td>Ikramuddin et al (2014)^4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active</td>
<td>24.4</td>
<td></td>
<td>3.7^b</td>
</tr>
<tr>
<td>Sham</td>
<td>15.9</td>
<td></td>
<td>NR</td>
</tr>
<tr>
<td>Mean diff (95% CI)</td>
<td>8.5 (3.1 to 13.9)^a</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CI: confidence interval; diff: difference; EWL: excess weight loss (calculated as difference between pre- and posttreatment weights divided by difference between pretreatment weight and ideal body
weight. Body mass index of 25 kg/m² was considered ideal); NR: not reported; RCT: randomized controlled trial.

a For a >10% difference.
b Single group comparison; FDA objective of <15% was met.

The primary efficacy outcomes were not met in either RCT. The difference in mean percent excess weight loss (EWL) was the sole primary efficacy outcome in the EMPOWER study and a coprimary outcome in the ReCharge study. This outcome was evaluated in both trials using a superiority margin of 10% (ie, the efficacy objective would be met only if there was a >10% difference between groups in EWL). U.S. Food and Drug Administration (FDA) documents have indicated the unattained 10% margin was considered to indicate a clinically meaningful difference in weight loss between active and sham treatment groups.5

For the ReCharge trial, however, in addition to the primary efficacy analysis, the authors conducted a post hoc analysis that evaluated the difference in EWL between groups using a 2-sided t-test with no superiority margin. In this post hoc analysis, the difference between groups (8.5% EWL; 95% confidence interval [CI], 3.1% to 13.9%) was statistically significant. (The difference between groups in percent EWL in the EMPOWER study was 1%.)

The outcome used in these studies was percent EWL, and modest changes in this outcome may translate to a relatively small amount of weight loss relative to total weight for patients with morbid obesity. Mean initial body weight in the ReCharge trial was 113 kilograms (249 pounds) in the active treatment group and 116 kilograms (255 pounds) in the sham group. Mean excess body weight was 44 kilograms (97 pounds) in the treatment group and 45 kilograms (99 pounds) in the sham group. Thus, a difference of 10% EWL, used in the primary analyses, represents a difference of only about five kilograms (ten pounds) in absolute weight loss and a 4% difference in absolute body weight.

The ReCharge study had a second primary outcome, which would have been met if at least 55% patients in the active treatment group had achieved at least 20% EWL and at least 45% had achieved at least 25% EWL. This outcome was not achieved; the data showed that 52% of patients in the active treatment group achieved at least 20% EWL and 38% achieved at least 25% EWL. In the EMPOWER study, groups did not differ significantly on the secondary outcome measure (percent of patients achieving at least 25% EWL).

In post hoc subgroup analysis of the EMPOWER trial, longer duration of device use per day was associated with a larger percent EWL. However, this improvement occurred in the sham group as well as the active treatment group. For example, percent EWL among patients who used the device for less than 6 hours a day was 5% in the active treatment group and 6% in the sham group, whereas percent EWL among patients who used the device for at least 12 hours a day was 30% and 22%, respectively. This finding suggests a substantial placebo effect associated with device use.
Both trials met their primary safety outcomes, which related to serious adverse events. However, there were frequent nonserious adverse events. Rates of key adverse events (all severity levels) in the ReCharge trial are shown in Table 3. Most were of mild or moderate severity. The authors of the EMPOWER trial did not report individual adverse events.

### Table 3. Most Common Adverse Events in the ReCharge Trial

<table>
<thead>
<tr>
<th>Adverse Events</th>
<th>No. (%) of Patients</th>
<th>Treatment Group (n=162)</th>
<th>Sham Group (n=77)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain, neuroregulator site</td>
<td>61 (38)</td>
<td>32 (42)</td>
<td></td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>38 (23)</td>
<td>3 (4)</td>
<td></td>
</tr>
<tr>
<td>Pain, other</td>
<td>37 (23)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Pain, abdominal</td>
<td>20 (12)</td>
<td>2 (3)</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>11 (7)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Dysphagia</td>
<td>13 (8)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Belching</td>
<td>13 (8)</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Additional information on the ReCharge trial design and findings has been reported in FDA documents. The trial was designed to evaluate primary endpoints at 12 months and to follow patients to 5 years postimplant. Patients were blinded until 12 months and unblinding began once all patients had completed the 12-month follow-up. After the 12-month follow-up, sham patients had the option to cross over into the active treatment group. At 18 months, follow-up data (n=159) were reported for 117 (72%) patients initially assigned to the active treatment group and 42 (55%) assigned to the sham treatment group. The number of patients in the sham group who crossed over to active treatment and the timing of unblinding was not reported. At 18 months, the mean percent EWL was 25.3% in the active treatment group and 11.7% in the sham group; the mean between-group difference was 13.5% (95% CI, 5.7% to 21.3%). In this analysis, the treatment group maintained the weight loss they achieved at 12 months, and the control group gained weight. Nearly half of the patients initially randomized to the sham group were not included in the 18-month analysis, which limits the ability to draw conclusions about these data. In addition, the 18-month analysis could have been biased by unblinding, which occurred after all patients completed the 12-month follow-up. In the 12-month sham intervention phase of the trial, patients in both groups experienced decreased hunger, increased cognitive restraint, and decreased food intake. It is likely that unblinding could have had an impact on these factors. The FDA documents also reported longer-term safety data. Analyses of data up to 48 months from the EMPOWER trial and 18-month data from the ReCharge trial did not identify any deaths or unanticipated serious adverse events. There were 13 surgical explants through 12 months (5 in the active treatment group, 8 in the sham group) and an additional 16 explantations between 12 and 18 months. Reasons for explant included the patient decision, pain, and need for magnetic resonance imaging.

Eighteen-month follow-up data from the ReCharge trial were published by Shikora et al (2015). They reported on a larger proportion of the patient population than
that discussed in the FDA documents: in addition to the 159 (67%) of 239 randomized patients who completed the 18-month follow-up, the 2015 analysis included 30 patients who missed the 18-month analysis but had a visit at 16 or 17 months. The additional patients included 11 from the active treatment group and 19 from the sham group, comprising 188 patients (79% of those originally randomized). At 18 months, the mean percent EWL noted was 23.5% (95% CI, 20.8% to 26.3%) in the active treatment group and 10.2% (95% CI, 6.0% to 14.4%) in the sham group. The mean between-group difference in percent EWL was 13.4% (95% CI, 8.4% to 18.4%). The authors also evaluated the potential impact of blinding on outcomes and found no statistically significant effect; their findings were similar to the analysis restricted to patients who remained blinded at 18 months. The percentages of EWL at 18 months in this 2015 analysis of ReCharge trial data were also similar to those previously reported in the FDA documents, although this sample size was larger, reducing potential bias from missing data. However, because this post hoc analysis incorporated 16- and 17-month data in addition to 18-month data, the authors considered these results preliminary or hypothesis-generating.

Twenty-four-month outcomes from ReCharge were published by Apovian et al (2017). The investigators noted that the sham arm was no longer a valid comparator at 24 months due to crossovers, dropouts, and patient unblinded at 12 months. There was no prespecified statistical analysis plan for assessments after the 12-month primary outcome assessment, including those in this 2017 article. A total of 103 (43%) patients of 239 randomized patients completed the 24-month follow-up. Their mean EWL was 21% (95% CI, 16% to 26%) and mean total weight loss was 8% (95% CI, 6% to 10%). No serious treatment-related adverse events were reported in the 18- to 24-month time period. The analysis lacked a blinded comparison group, and, like the 18-month data, was post hoc.

Section Summary: Vagus Nerve Blocking Therapy for Obesity
Two sham-controlled RCTs have been published. The primary efficacy outcome (at least a 10% difference between groups) was not met for either trial. In the first trial (EMPOWER), the observed difference in EWL between groups at 12 months was 1%. In the more recent trial (ReCharge), the observed difference in EWL between groups at 12 months was 8.5%; a post hoc analysis found this difference statistically significant, but the magnitude of change may not be viewed as clinically significant according to investigators’ original trial design decisions. Additional analyses of data from ReCharge found a difference in EWL at 18 months of approximately 13% in 79% of initially randomized patients and a mean EWL of 21% at 24 months in 43% of initially randomized patients. However, analyses beyond 12 months were post hoc, considered preliminary, and need to be replicated in other appropriately designed RCTs. In addition, the 18- and 24-month data have potential biases, including missing data and unblinding. Moreover, the 18-month analysis combined data from different follow-up visits and the 24-month analysis lacked a control group. The two RCTs found that vagus nerve blocking was reasonably safe in terms of serious adverse events during follow-up, although a substantial number of mild and moderate adverse events were reported.
Summary of Evidence
For individuals with obesity who receive vagus nerve blocking therapy, the evidence includes two sham-controlled randomized trials. The relevant outcomes are change in disease status, morbid events, quality of life, and treatment-related morbidity. The primary efficacy outcome (at least a 10% difference between groups at 12 months) was not met for either trial. In the first trial (EMPOWER), the observed difference in EWL between groups at 12 months was 1%. In the more recent trial (ReCharge), the observed difference in EWL between groups at 12 months was 8.5%; a post hoc analysis found this difference statistically significant, but the magnitude of change may not be viewed as clinically significant according to investigators’ original trial design decisions. Post hoc analyses of longer-term data have been published and are subject to various biases, including missing data and unblinding at 12 months. The evidence is insufficient to determine the effects of the technology on health outcomes.

SUPPLEMENTAL INFORMATION

Practice Guidelines and Position Statements
A position statement published by the American Society for Metabolic and Bariatric Surgery (2016) includes the following conclusions on vagus nerve blocking therapy for the treatment of obesity:

1. Reversible vagal nerve blockade has been shown to result in statistically significant EWL [excess weight loss] at 1 year compared with a control group in one of 2 prospective randomized trials.
2. Reversible vagal nerve blockage has been shown to have a reasonable safety profile with a low incidence of severe adverse events and a low revisional rate in the short term. More studies are needed to determine long-term reoperation and explantation rates.
3. The prospective collection of VBLOC [vagus nerve blocking] outcomes as part of the national center of excellence databases is encouraged to establish the long-term efficacy of this new technology.

U.S. Preventive Services Task Force Recommendations
The U.S. Preventive Services Task Force (2018) updated recommendations for screening and management of obesity in adults. The Task Forcerecommended screening all adults for obesity and referring those with a body mass index of 30 kg/m² or higher to intensive, multicomponent behavioral interventions. Vagus nerve blocking therapy and other surgical interventions were not addressed in the recommendations or literature review.

Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.
**Ongoing and Unpublished Clinical Trials**
A search of ClinicalTrials.gov in January 2019 did not identify any ongoing or unpublished trials that would likely influence this review.

**REFERENCES**

**Billing Coding/Physician Documentation Information**

**0312T** Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming

**0313T** Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator

**0314T** Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator

**0315T** Vagus nerve blocking therapy (morbid obesity); removal of pulse generator

**0316T** Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator

**0317T** Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed

**ICD-10 Codes:**

**E66.01** Morbid (severe) obesity due to excess calories
Additional Policy Key Words
N/A

Policy Implementation/Update Information
4/1/16  New policy; considered investigational.
4/1/17  Title changed from “Vagal” to “Vagus”. No policy statement changes.
4/1/18  No policy statement changes.
4/1/19  No policy statement changes.
4/1/20  No policy statement changes.

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.