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Subject: Bariatric Surgery

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DESCRIPTION:

Morbid obesity is defined as a body mass index (BMI) greater than 40 kg/m^2, or a BMI greater than 35 kg/m^2 with associated complications including, but not limited to, diabetes, hypertension, or obstructive sleep apnea. The first line of treatment of morbid obesity is dietary and lifestyle changes. When conservative measures fail, some individuals may consider surgical approaches. Surgery for morbid obesity, termed bariatric surgery, is performed for the treatment of morbid (clinically severe) obesity.

The evidence for bariatric surgery in individuals younger than age 18 years consists primarily of studies of adolescents, with a lack of evidence for younger children. There is limited evidence on which to assess the long-term impacts of bariatric surgery for adolescents. Very severely obese (BMI ≥ 40 kg/m^2) adolescents with serious obesity-related comorbidities that are poorly controlled, and adolescents who have a BMI of ≥ 50 kg/m^2 with less serious comorbidities may be considered for bariatric surgery. There is greater emphasis on issues of developmental and skeletal maturity in adolescents.

The choice of procedure in adolescents may differ from adults, but there is a lack of consensus as to the preferred procedure(s) for adolescents. As in adults, laparoscopic gastric bypass is the most common procedure in adolescents. Devices that are used for laparoscopic adjustable gastric banding do not have FDA-approval in the U.S. for individuals younger than age 18 years.

Bariatric surgery procedures may be restrictive procedures, malabsoprtive procedures, or a combination of the two. The different types of bariatric surgery procedures are described below.

Open and laparoscopic Roux-en-Y Gastric Bypass (RYGB) (up to 150 cm)

The gastric bypass procedure involves both a restrictive and a malabsorptive component, with horizontal or vertical partition of the stomach performed in association with a Roux-en-Y procedure (i.e., a gastrojejunal anastomosis). 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.” Operative complications include leakage and marginal ulceration at the anastomotic site. Because the normal flow of food is disrupted, there are more metabolic complications compared to other gastric restrictive procedures, including iron deficiency anemia, vitamin B-12 deficiency, and hypocalcemia, all of which can be corrected by oral supplementation. 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.

Laparoscopic Adjustable Gastric Banding (LAGB) (eg, LapBand®, Realize®)

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

Biliopancreatic Bypass with Duodenal Switch (BPD/DS)

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

Sleeve gastrectomy (SG)

A sleeve gastrectomy is an alternative approach to gastrectomy that can be performed on its own, or in combination with malabsorptive procedures (most commonly biliopancreatic diversion with duodenal switch). In this procedure, the greater curvature of the stomach is resected from the angle of His to the distal antrum, resulting in a stomach remnant shaped like a tube or sleeve. The pyloric sphincter is preserved, resulting in a more physiologic transit of food from the stomach to the duodenum, and avoiding the dumping syndrome (overly rapid transport of food through the stomach into the intestines) that is seen with distal gastrectomy. This procedure can be performed by the open or laparoscopic technique. Some surgeons have proposed the sleeve gastrectomy as the first in a 2-stage procedure for very high-risk individuals.

Biliopancreatic Bypass Diversion (Scopinaro procedure)

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

- A distal gastrectomy induces a temporary early satiety and/or the dumping syndrome in the early postoperative period, both of which limit food intake.
- A 200 cm long “alimentary tract”, consisting of 200 cm of ileum connecting the stomach to a common distal segment.
- A 300 to 400 cm “biliary tract” which connects the duodenum, jejunum, and remaining ileum to the common distal segment.
- A 50 to 100 cm “common tract,” 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 a selective malabsorption. The length of the common segment will influence the degree of malabsorption.
- Because of the high incidence of cholelithiasis associated with this procedure, cholecystectomy is usually performed.

Long-limb gastric bypass (> 150cm)

Recently, variations of gastric bypass procedures have been described, consisting primarily of long-limb Roux-en-Y procedures, 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, i.e., either by resection or stapling along the horizontal or vertical axis. Unlike the traditional gastric bypass, which is essentially 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.

Vertical Banded Gastroplasty (VBG)

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

Mini-Gastric Bypass

A variant of the gastric bypass, called the “mini-gastric bypass” 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.

Endoluminal (also called endosurgical, endoscopic or natural orifice) bariatric procedures

With these procedures, access to the relevant anatomical structures is gained through the mouth without skin incisions. Primary and revision bariatric procedures are being developed to reduce the risks associated with open and laparoscopic interventions. Examples of endoluminal bariatric procedures studied include gastroplasty using a transoral endoscopically guided stapler, and placement of devices such as a duodenal-jejeunal sleeve and gastric balloon. Endoluminal techniques for bariatric surgery include but may not be limited to the following:

- **Endoscopic duodenal-jejunal bypass:** A procedure that involves an endoscopically placed duodenal-jejunal bypass liner (EndoBarrier™) is utilized to promote weight loss by preventing food from coming in contact with the intestinal wall, and inhibiting the absorption of food and nutrients in individuals who are potential candidates for bariatric surgery.

- **Endoscopic gastroplasty:** This is an incision-less, reversible procedure in which the stomach size is restricted with staples or sutures by using endoscopic surgical tools guided through the mouth and esophagus into the stomach.

- **Endoscopic procedures** (e.g., insertion of the StomaphyX™ device, ROSE procedure; restorative obesity surgery) to treat weight gain after bariatric surgery to remedy large gastric stomas or large gastric pouches.

Laparoscopic Gastric Plication

Laparoscopic gastric plication 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 specifics of the technique are not standardized.

Single anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S)

Single anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S) is a bariatric surgery procedure that is based on the biliopancreatic diversion. A sleeve gastrectomy is performed and is then followed by an end-to-side duodenoileal diversion. Preservation of the pylorus makes a one loop reconstruction possible. This is thought to reduce the time required for surgery, and eliminate the need for a mesentery opening.

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. The total amount of data on aspiration therapy is very limited. and additional studies are needed before conclusions can be drawn about the long-term effects of treatment on weight loss, metabolism, and nutrition.

POSITION STATEMENT:

Bariatric surgery may be excluded by contract. Please refer to the individual member contract benefit language.

When **selection criteria** are met, the following bariatric surgery procedures performed for the treatment of clinically severe (morbid) obesity **meet the definition of medical necessity:**

- Open or laparoscopic Roux-en-Y gastric bypass (RYGB) (up to 150cm) (CPT codes 43846, 43644)
- Laparoscopic adjustable gastric banding (LAGB) (FDA approved ≥ 18 years) (CPT code 43770)
- Biliopancreatic bypass with duodenal switch (BPD/DS) (CPT code 43845)
- Sleeve gastrectomy (SG) (CPT code 43775)
- Biliopancreatic bypass diversion (Scopinaro) (CPT code 43847)
- Vertical banded gastroplasty (CPT code 43842)

Selection criteria

Adults

- Severely obese with a **BMI ≥ 40 kg/m2, OR**
- Severely obese with a **BMI ≥ 35 kg/m2**, with at least one comorbidity refractory to medical management (e.g., type 2 diabetes, hypertension, coronary artery disease, obstructive sleep apnea, GERD, osteoarthritis, pseudotumor cerebri), **AND**
- Does not have a medically treatable cause for obesity (e.g., thyroid or other endocrine disorder), **AND**
- Has made multiple attempts at non-surgical weight loss (e.g., diet, exercise, medications), **AND**
- Has received psychological or psychiatric evaluation with counseling as needed, prior to surgical intervention.

Adolescents (< age 18 years)

- Severely obese with a **BMI ≥ 50 kg/m2**, with at least one less serious comorbidity refractory to medical management (e.g., hypertension, dyslipidemia, venous stasis disease, coronary artery disease, nonalcoholic fatty liver disease, GERD, osteoarthritis, recurrent soft tissue infections, significant impairment in activities of daily living), **OR**
- Severely obese with a **BMI ≥ 40 kg/m2**, with at least one serious comorbidity refractory to medical management (e.g., obstructive sleep apnea, type 2 diabetes, pseudotumor cerebri), **AND**
- Does not have a medically treatable cause for obesity (e.g., thyroid or other endocrine disorder), **AND**

- Has attained a minimum of Tanner stage 4 pubertal development, **AND**
- Has reached skeletal maturity, **AND**
- Has made multiple attempts at non-surgical weight loss (e.g., diet, exercise, medications), **AND**
- Has received psychological or psychiatric evaluation with counseling as needed, prior to surgical intervention.

Any bariatric surgical procedure for the treatment of obesity in individuals with a BMI < 35 kg/m2 **does not meet the definition of medical necessity.**

The bariatric surgery procedures listed below are considered **experimental or investigational**, as there is insufficient clinical evidence in the peer-reviewed literature to support safety, effectiveness and long-term effects on health outcomes.

- Long-limb gastric bypass (> 150cm) (CPT code 43847)
- Laparoscopic gastric plication (also known as laparoscopic greater curvature plication)
- Mini-gastric bypass (using a Billroth type anastomosis)
- Insertion of the StomaphyX™ device
- Endoscopic gastroplasty
- Endoscopically placed duodenojejunal sleeve
- Intragastric balloons
- ROSE procedure
- Restorative obesity surgery
- Biliopancreatic bypass without duodenal switch (CPT code 43845)
- Two-stage bariatric surgery procedures (e.g., sleeve gastrectomy as an initial procedure followed by biliopancreatic diversion at a later time)
- Any bariatric surgical procedure as a treatment of type 2 diabetes in individuals with a BMI < 35 kg/m2
- ”Stomach stapling”, jejunoileal bypass, silastic ring vertical gastric bypass (Fobi pouch; limiting proximal gastric pouch)
- Single anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S)
- Aspiration therapy device
- Any bariatric surgery procedure performed as the primary treatment for gastroparesis, intractable nausea, gallstones, urinary stress incontinence, gynecological abnormalities, osteoarthritis

Revision bariatric surgery

Revision bariatric surgery to address perioperative or late complications of a bariatric procedure (e.g., obstruction, stricture, erosion, band slippage/herniation, fistula, disruption/leakage of a suture/staple line, pouch enlargement due to vomiting, nonabsorption resulting in hypoglycemia or malnutrition, weight loss of 20% or more below ideal body weight) **meets the definition of medical necessity**.

Revision of a primary bariatric procedure that has failed due to dilation of the gastric pouch or dilation proximal to an adjustable gastric band **meets the definition of medical necessity** when **ALL** of the following are met:

- The dilation is documented by upper gastrointestinal examination or endoscopy
- The initial procedure induced weight loss prior to pouch dilation
- The individual has been compliant with a prescribed nutrition and exercise program

Revision bariatric surgery to correct stretching of a stomach pouch created by a previous bariatric surgery procedure, due to overeating, is not considered a surgical complication. Revision surgery for this condition **does not meet the definition of medical necessity**.

BILLING/CODING INFORMATION:

CPT Coding:

43621	Gastrectomy, total; with Roux-en-Y reconstruction
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (Roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption [**NOTE:** 43645 was introduced in 2005 to specifically describe a laparoscopic malabsorptive procedure. However, the code does not describe any specific malabsorptive procedure]
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g. gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric

	restrictive device and subcutaneous port components
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e, sleeve gastrectomy)
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy (may be done laparoscopically)
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption (may be done laparoscopically)
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only

NOTE: CPT code 43847 may be used to report biliopancreatic bypass (Scopinaro procedure) **OR** long-limb gastric bypass (> 150 cm). CPT code 43846 explicitly describes a short limb (< 150 cm) Roux-en-Y gastroenterostomy, and thus is not appropriate to report long-limb gastric bypass.

HCPCS Coding:

S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline

LOINC Codes:

The following information may be required documentation to support medical necessity: physician history and physical (including co-morbidities and history of attempt(s) of non-surgical weight-loss program(s),

physician progress notes, laboratory studies (including most recent TSH level), psychosocial assessment, height, weight and BMI.

Documentation Table	LOINC Codes	LOINC Time Frame Modifier Code	LOINC Time Frame Modifier Codes Narrative
Physician history and physical	28626-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Attending physician progress notes	18741-9	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Laboratory studies	26436-6	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Psychosocial well-being, addressed in care plan	58168-6	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Body mass index	39156-5	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Height and weight	54567-3	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Co-morbidities and complications	42126-3	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Endocrine screen assessment	39177-1	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.

REIMBURSEMENT INFORMATION:

Bariatric surgical procedures are reimbursed based on the procedure performed and not the surgical technique used (e.g., microsurgical, laser, laparoscopic, robot-assisted).

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage:

The following National Coverage Determinations (NCDs) were reviewed on the last guideline reviewed date: Bariatric Surgery for Treatment of Morbid Obesity (100.1), Surgery for Diabetes (100.14), Gastric Balloon for Treatment of Obesity (100.11), and Intestinal Bypass Surgery (100.8) located at cms.gov.

The following Local Coverage Determination (LCD) was reviewed on the last guideline reviewed date: Surgical Management of Morbid Obesity (L33411) located at fcso.com.

DEFINITIONS:

Gastric banding: a synthetic band rather than staples is used to divide the stomach into a small upper pouch and a lower portion).

Jejunoileal bypass: shunts food from the jejunum into the ileum, bypassing the small intestine.

Pseudotumor cerebri: when elevated intracranial pressure occurs with no obvious cause; symptoms mimic those of a brain tumor, but no tumor is present.

Skeletal maturity: when the bones and spine have stopped growing; a system of fused skeletal bones, which occurs when bone growth ceases after puberty.

Tanner staging: also known as the sexual maturity rating; breaks down the visible changes during puberty into stages of sexual development.

RELATED GUIDELINES:

Gastric Electrical Stimulation, 01-91000-04
Reconstructive Surgery/Cosmetic Surgery, 02-12000-01
Vagus Nerve Stimulation, 02-61000-22

OTHER:

None applicable.

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy & Coverage Committee on 08/24/17.

GUIDELINE UPDATE INFORMATION:

10/15/99	Medical Coverage Guideline developed.
09/15/01	Various revisions.
01/01/02	Coding changes.
10/15/02	Annual review. Added Roux-enY anastomosis or vertical-banded as covered services. Added biliopancreatic bypass with duodenal switch and very long limb gastric bypass procedure (e.g., greater than 100 cm) as non-covered services.
05/15/03	Revised to clarify coding of the various procedures; criteria revised and is consistent with Inter-Qual criteria.
09/15/03	Coverage criteria for psychological testing/counseling revised.
10/15/03	Reversed investigational status for CPT code 43847 and provided coverage criteria for long-limb Roux-en-Y procedures up to 150 cm.
01/01/04	Annual HCPCS coding update.
04/01/04	2nd Quarter HCPCS coding update; added S2082 and S2083.
07/15/04	Scheduled review; no changes.
01/01/05	HCPCS coding update. Added 43644, 43645, 43845, S2082, and S2083. Revised descriptor for 43846, and deleted S2085.

05/15/05	Unscheduled review of the non-covered statement for laparoscopic adjustable gastric banding (Lap-Band); coverage statement unchanged.
01/01/06	Annual HCPCS coding update (added 43770 – 43774; deleted S2082).
04/15/06	Scheduled review; removed investigational statement for laparoscopic adjustable gastric banding and biliopancreatic diversion with duodenal switch; updated coding, index terms, and references.
05/15/06	Scheduled review; removed investigational statement for laparoscopic adjustable gastric banding and biliopancreatic diversion with duodenal switch; updated coding, index terms, and references; added age limitation of 18 years and older.
05/15/07	Scheduled annual review; reformatted guideline; modified coverage criteria regarding non-surgical weight loss programs; added description information and investigational statement regarding sleeve gastrectomy; updated references.
01/01/08	Annual HCPCS coding update: descriptor revisions for codes 43770 – 43774. Revised verbiage regarding adjustable gastric banding.
05/15/08	Scheduled annual review. Add investigational statement for endoscopic procedures. Update references.
05/15/09	Scheduled review; add CPT language for postoperative adjustment of gastric band to reimbursement section; updated position statement and description for long limb Roux-en Y greater than 150 cm; add presence of comorbidities to position statement; revise investigational statement to include transoral surgical procedures.
01/01/10	Annual HCPCS coding update: added CPT code 43775.
06/15/10	Annual review; no change in position statement. References updated.
10/01/10	4th Quarter HCPCS coding update consisting of adding ICD-9 diagnosis codes V85.41, V85.42, V85.43, V85.44 and V85.45.
11/15/10	Revision; position statement revised to include coverage criteria for Long-limb Gastric Bypass and Sleeve Gastrectomy; Medicare Advantage exception added; related ICD-10 codes added; Certificate of Medical Necessity added; references updated; guideline reformatted.
06/15/11	Annual review; no change in position statements. Updated Medicare Advantage program exception (delete CPT code 43775). Updated references.
09/15/11	Revision; formatting changes.

04/01/12	Revision; updated ICD10 coding with new and revised codes.
08/01/12	Scheduled review. Revised description section. Revised position statement; added coverage criteria for Biliopancreatic Bypass (i.e., the Scopinaro procedure) and designated Long-Limb Roux-en-Y (LLRY) as E/I. Removed time requirements for duration of BMI and attempts at non-surgical weight loss. Revised Medicare Advantage program exception. Updated references and reformatted guideline.
11/15/13	Scheduled review. Revised MCG title and description section. Revised position statement (added criteria for adolescents, designated vertical banded gastroplasty as E/I). Revised ICD9/ICD10 coding sections, program exception section (Medicare Advantage), related guidelines, and definitions. Updated references.
05/15/14	Unscheduled review (mini-gastric bypass); position statement maintained. Revised CPT coding section and updated references.
01/01/15	Scheduled review. Revised description section, position statement and program exceptions. Updated references.
12/15/15	Scheduled review. Revised position statement (added coverage for vertical banded gastroplasty). Updated Program Exceptions section and references.
04/15/16	Revision; added coverage statement (E/I) for anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S).
10/01/16	Revision: Billing/Coding Information section updated.
06/15/17	Scheduled review. Revised description section. Added coverage statement (E/I) for aspiration therapy. Updated references.
09/15/17	Revision: added coverage statement for bariatric surgery performed as primary treatment for conditions other than morbid obesity. Added code 43633. Updated references.
12/15/18	Revision; added code 43621.