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Subject: Bariatric Surgery

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DESCRIPTION:

Bariatric surgery is a treatment for morbid obesity in individuals who fail to lose weight with conservative measures. There are numerous gastric and intestinal surgical techniques available. While these techniques have heterogeneous mechanisms of action, the result is a smaller gastric pouch that leads to restricted eating. However, these surgeries may lead to malabsorption of nutrients or eventually to metabolic changes.

Review and Analysis of Evidence: The evidence for bariatric surgery for adults with class III obesity 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 versus conservative treatment, or the comparative efficacy of different bariatric surgery techniques. RCTs are difficult in bariatric surgery because many experts consider it inappropriate or unethical to randomize patients to bariatric surgery. The Swedish Obese Subjects (SOS) trial is the most influential study of bariatric surgery versus conservative treatment. A 2023 UpToDate review titled “Obesity in adults: Overview of management” (Perreault et al) states “Bariatric surgical approaches can achieve as much as a 40 percent weight loss at 12 to 18 months post-procedure, with better long-term weight loss maintenance than nonsurgical approaches. In addition to resulting in greater weight loss, bariatric surgery may also reduce obesity related morbidity more than nonsurgical weight loss approaches. In the Swedish Obese Subjects (SOS) after 10 to 20 years of follow-up, patients receiving bariatric surgery (including gastric banding, vertical banded gastroplasty, gastric bypass) had greater reductions in obesity-related morbidity (diabetes, hypertension, dyslipidemia) and overall mortality than those in the conventionally treated group (hazard ratio [HR] 0.71, 95% CI 0.54-0.92). Further, in systematic reviews and meta-analyses of randomized trials comparing bariatric surgery to nonsurgical treatment of obesity (diet, exercise, weight-reducing

drugs, behavioral therapy), there was greater weight loss and higher remission rates of type 2 diabetes in the bariatric surgery group." Regarding bariatric surgery for adolescent children, Qi et al (2017) published a systematic review and meta-analysis on the use of bariatric surgery for the treatment of adolescents with obesity. Overall results showed significant improvements in BMI as well as glycemic and lipid control with various bariatric surgery techniques. RYGP showed the largest improvements compared with other procedures, with LAGB and SG also showing improvements in this population.

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)
- Laparoscopic adjustable gastric banding (LAGB)
- Open or laparoscopic biliopancreatic diversion with or without duodenal switch
- Sleeve gastrectomy (SG)
- Vertical banded gastroplasty (VBG)

Selection criteria

Adults

- Class III obesity **(BMI ≥ 40 kg/m2), OR**
- Class II obesity **(BMI 35.0 to 39.9 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 comorbidities), **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)

- **Class III obesity (BMI ≥ 40 kg/m2), OR**
- **Class II obesity (BMI 35.0 to 39.9 kg/m2),** with at least one serious comorbidity refractory to medical management (e.g., Type 2 diabetes, hypertension, coronary artery disease, obstructive sleep apnea, GERD, osteoarthritis, pseudotumor comorbidities), **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 or 5 pubertal development and final or near-final adult height, **AND**
- Has made multiple attempts at non-surgical weight loss (e.g., diet, exercise, medications), **AND**
- Psychological evaluation confirms the stability and competence of the family unit

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.

- Any bariatric surgery procedure performed as the primary treatment for gastroparesis, intractable nausea, gallstones, urinary stress incontinence, gynecological abnormalities, osteoarthritis, infertility, or idiopathic intracranial hypertension
- Any bariatric surgical procedure as a treatment of type 2 diabetes in individuals with a BMI < 35 kg/m2
- Aspiration therapy (e.g., AspireAssist device)
- Endoscopic closure device (Over the Scope [OTSC]; Apollo OverStitch; StomaphyX)
- Intragastric balloons (including, but not limited to Obalon Balloon System and ReShape Integrated Dual Balloon System)
- Long-limb gastric bypass
- Laparoscopic gastric plication (also known as laparoscopic greater curvature plication)
- Mini-gastric bypass
- Mini-sleeve gastrectomy
- Natural orifice transoral endoscopic surgery (NOTES) techniques for bariatric surgery (including, but may not be limited to gastrointestinal liners, endoscopic duodenal-jejunal bypass, endoscopic gastrointestinal bypass devices such as EndoBarrier and ValenTx Endo Bypass System)
- One-anastomosis gastric bypass (OAGB) (loop gastric bypass)
- Open adjustable gastric banding
- Restorative obesity surgery, endoluminal (ROSE) procedure
- Silastic ring vertical gastric bypass (Fobi pouch)
- Single anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S)
- Sleeve gastrectomy with single anastomosis duodeno-ileal bypass (SIPS)
- Transoral gastroplasty (TG) (vertical sutured gastroplasty; endoluminal vertical gastroplasty; endoscopic sleeve gastroplasty)
- Transoral outlet reduction (TORe)
- Two-stage bariatric surgery procedures (e.g., sleeve gastrectomy as an initial procedure followed by biliopancreatic diversion at a later time)

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, documented gastroesophageal reflux disease (GERD) refractory to maximal medical management, 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:

0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon **(investigational)**
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon **(investigational)**
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s) **(investigational)**
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 Co-Morbid Conditions Related to Morbid Obesity (100.1), 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 cms.gov.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request

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 and Coverage Committee on 01/23/25.

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.
03/15/20	Scheduled review. Revised description and position statement. Updated references.
05/15/22	Scheduled review. Revised position statement and updated references.
01/01/23	Annual CPT/HCPCS coding update. Added 43290, 43291.
05/25/23	Update to Program Exceptions section.
08/15/23	Revision. Updated references and maintained position statement.
01/01/24	Annual CPT/HCPCS coding update. Added 0813T.
02/15/24	Scheduled review. Revised description, maintained position statements, and updated references.
02/15/25	Scheduled review. Maintained position statement and updated references.