

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
MG.MM.SU.18	7/11/2025	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies (LMRP). All coding and web site links are accurate at time of publication.

Definitions

1. **Bariatric surgical procedure types** — restrictive, malabsorptive and combined, all of which may be performed using either the laparoscopic or open approach.
 - a. Restrictive — the basic philosophy of restrictive procedures is to create a small gastric reservoir that forces the patient to eat less at any one time. This objective is achieved by reducing the size of the stomach pouch to 30 mL or less and leaving only a small channel to the remaining stomach.
 - b. Malabsorptive — the goal of purely malabsorptive procedures is to bypass a major portion of the absorptive surface of the small intestine for the achievement of rapid, sustained weight loss without a necessary change in eating habits. Purely malabsorptive procedures (without a restrictive component) are not recommended because of the potential for complications, including liver failure and electrolyte depletion.
 - c. Combined restrictive and malabsorptive (hybrid techniques) — the basic philosophy of combined restrictive and malabsorptive procedures is to balance the benefits and risks of the two approaches.

2. **Body Mass Index (BMI)** — a quantitative method of defining obesity in a ratio of weight to height (kg/m^2).

3. **Classification**

Adults (≥ 18 years of age)	BMI
Overweight	25–29.9 kg/m^2
Obese (class I)	30–34.9 kg/m^2
Severe obesity (class II)	35–39.9 kg/m^2
Clinically severe (also referred to as extreme or morbid) obesity (class III)	40–49.9 kg/m^2
Super obesity	50–59.9 kg/m^2
Super-super obesity	60+ kg/m^2
Children/adolescents (< 18 years of age)	BMI
Class II obesity	$\geq 120\%$ to $< 140\%$ of the 95th percentile or a BMI $\geq 35 \text{ kg}/\text{m}^2$ to $< 39 \text{ kg}/\text{m}^2$, whichever is lower based on age and sex
Class III obesity	$\geq 140\%$ of the 95th percentile or BMI $\geq 40 \text{ kg}/\text{m}^2$, whichever is lower based on age and sex

4. **Biliopancreatic Diversion with duodenal switch (BPD/DS)** — a combined malabsorptive / restrictive procedure whereby a suprapapillary Roux-en-Y duodeno-jejunosomy is performed in combination with a 70%–80% greater curvature gastrectomy (sleeve resection of the stomach; continuity of the gastric lesser curve is maintained while simultaneously reducing stomach volume). A long-limb Roux-en-Y is then created. The efferent limb acts to decrease overall caloric absorption and the long biliopancreatic limb, diverting bile from the alimentary contents, is intended specifically to induce fat malabsorption.
5. **Laparoscopic adjustable gastric banding (LAGB)** — a gastric-restrictive implant device used as an alternative to a gastric-restrictive surgery procedure to treat morbid obesity. The system consists of a band of silicone elastomer with an inflatable inner shell and a buckle closure connected by tubing to an access port placed outside the abdominal cavity. The inner diameter of the band can be readily adjusted by the addition or removal of saline through the access port. The band is placed laparoscopically around the upper stomach, 1 cm below the esophagogastric junction. (Must be FDA-approved for Plan consideration) (Not covered for members < 18 years of age)
6. **Roux-en-Y gastric bypass (RYGB)** — a large portion (approximately 90%) of the stomach is excluded. A gastric pouch is created and anastomosed to the proximal jejunum, causing weight reduction due to a reduction of food intake and mild malabsorption.
7. **Single-anastomosis duodenoileal bypass with sleeve gastrectomy (SADI-S)** — a simplification of the duodenal switch (DS) in which the alimentary limb is eliminated, and the common channel is lengthened. The sleeve is created first, and the duodenum is

divided about 4 cm from the pylorus. A single anastomosis is then created between the side of the first or second part of the duodenum and the distal jejunum/proximal ileum, creating an afferent limb of biliopancreatic fluid and an efferent limb that acts like a common channel.

8. **Sleeve gastrectomy** — a new procedure that is becoming increasingly popular. In this operation, a tubular stomach is created along the lesser curvature by excising the greater curvature. Approximately an 80–90% gastrectomy is performed. This is a restrictive procedure and absorption remains normal.
9. **Vertical gastric banding (VGB) / vertical-banded gastroplasty (VBG) (vertical gastric stapling or partitioning)** — A vertical row of staples and a horizontally placed reinforcing band are positioned across the stomach, creating a proximal pouch and narrowed food outlet. Patients become full post ingestion of only small food amounts.
10. **The Obesity Surgery Mortality Risk Score (OS-MRS)** — a risk stratification tool that physicians should utilize when determining candidacy of the BMI ≥ 50 kg/m² member. The OS-MRS assigns 1 point to each of 5 preoperative variables: Age, hypertension, male gender, known risk factors for pulmonary embolism (i.e., previous thromboembolism, preoperative vena cava filter, hypoventilation, pulmonary hypertension) and BMI.

Obesity Surgery Mortality Risk Score	
Risk factor	Points
Age > 45 years	1
Hypertension	1
Male sex	1
Risk factors for pulmonary embolism	1
Body mass index ≥ 50 kg per m ²	1
	Total: _____
<i>Risk group (score)</i>	<i>Postoperative mortality risk (deaths/total number of patients who underwent bariatric surgery)</i>
Low (0 or 1 points)	5/2164 (0.2%)
Moderate (2 or 3 points)	25/2142 (1.2%)
High (4 or 5 points)	3/125 (2.4%)

Guideline

Bariatric surgery is considered medically necessary when criteria A or B is met.

A. < 18 years of age utilizing any of the above [procedures](#) (except adjustable gastric banding) when either of the following criteria are met:

1. Class II obesity, BMI ≥ 35 kg/m² or 120% of the 95th percentile for age and sex, whichever is lower

- Clinically significant disease, examples include but are not limited to type 2 diabetes mellitus (T2DM), Idiopathic intracranial hypertension (IIH), and nonalcoholic steatohepatitis (NASH), Blount disease, (slipped capital femoral epiphysis (SCFE), Gastroesophageal reflux disease (GERD), obstructive sleep apnea (OSA) (apnea-hypopnea index [AHI] >5), cardiovascular disease risks (hypertension [HTN], hyperlipidemia, insulin resistance), depressed health-related quality of life
2. Class III obesity, BMI ≥ 40 kg/m² or 140% of the 95th percentile for age and sex, whichever is lower (comorbidities not required, but commonly present)

B. ≥ 18 years of age utilizing any of the above [procedures](#) (in conjunction with cholecystectomy if such is requested) when all of the following criteria are met:

1. Full growth achieved.
2. Absence of specific obesity etiology (i.e., endocrine disorders, e.g., adrenal or thyroid conditions, or treatment of metabolic cause provided, as applicable [does not pertain to diabetes]).
3. Psychological clearance by a mental health professional.

If the member has received any behavioral health issue intervention (i.e., counseling or drug therapy) within the past 12 months, then the mental health provider should indicate that the issue of surgery has been discussed with the member and that there are no identified contraindications to the proposed surgery.

In addition, the member should have no history of substance abuse, or if there is a positive history, the documentation should indicate that the member has been substance abuse free for > 1 year or that he/she is in a controlled treatment program and is stabilized.

Other contraindications include active eating disorders, active substance abuse and untreated psychiatric illness such as suicidal ideation, borderline personality disorder, schizophrenia, terminal illness and uncontrolled depression.

AND

4. BMI ≥ 40 kg/m² **or** BMI 35–39.9 kg/m² with ≥ 1 significant comorbidity.

Accompanying documentation of the following associated comorbid conditions and associated problems must be submitted; any of the following are applicable:

- a. Daily functional interference to the extent that performance is extensively curtailed.¹
- b. Documented circulatory insufficiency.
- c. Documented physical trauma secondary to obesity complications, which causes the member to be incapacitated.
- d. Documented respiratory insufficiency.
- e. Documented primary disease complication, as applicable:
 - i. Coronary heart disease and other atherosclerotic diseases.

¹ The member must be unable to participate in employment and/or normal activities as a result of the clinically severe obese condition, which could be resolved by weight reduction (e.g., treatable joint disease).

- ii. Hypertension.
- iii. Osteoarthritis.
- iv. Obstructive sleep apnea.
- v. Type 2 diabetes.

Gastric Band Adjustments

Appropriate as follows:

1. Reduction of band volume: Complaints of difficulty swallowing, persistent reflux or heartburn, nighttime coughing or regurgitation.

Reduction of band volume may also be appropriate in the setting of maladaptive eating habits such as eating only soft, carbohydrate and fat laden food due to inability to tolerate any solid foods. These complaints, however, should be taken in context with member's compliance with dietary follow up and recommendations.

2. Increase in band volume: Increased hunger, increased portion sizes.

Adjustments would be expected at approximately 6-week intervals until appropriate fill volume has been achieved (member is experiencing early and prolonged satiety with small meal sizes, satisfactory weight loss).

Adjustments should be performed in the outpatient setting and without fluoroscopic guidance unless the port is not palpable, there is difficulty accessing the port, or leakage is suspected.

Surgical Revision

Members are eligible for coverage of a surgical revision of a previous gastric restrictive surgery if it is medically necessary as a result of a complication of the original procedure; i.e.:

1. Staple disruption.
2. Obstruction or chronic stricture.
3. Severe esophagitis.
4. Dilatation of the gastric pouch in a member who experienced appropriate weight loss prior to the dilatation.

Note: Laparoscopic adjustable banding revisional surgery will be covered for band slippage or erosion, both of which are deemed urgent medical conditions.

Surgical Repetition

Members are eligible for coverage of repeat bariatric surgery if both of the following criteria are met:

1. Insufficient weight loss (success defined as a weight loss of > 50% of excess body weight)
2. The medically necessary criteria (as outlined above) are met.

Note: Member compliance with prescribed post-procedure nutrition and exercise program is prerequisite to consideration.

Postsurgical Panniculectomy Requests

(See [Cosmetic and Reconstructive Surgery Procedures](#) and/or [Abdominoplasty/Panniculectomy](#))

Procedure Codes

43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon (Medicaid and Medicare only)
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s) (Medicaid and Medicare only)
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
43659	Unlisted laparoscopy procedure, stomach
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, 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 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 (ie, 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
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy

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
43999	Unlisted procedure, stomach
47562	Laparoscopy, surgical; cholecystectomy
47600	Cholecystectomy
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline (Commercial and Medicaid only)

Diagnosis Codes

E66.01	Morbid (severe) obesity due to excess calories
Z68.35	Body mass index (BMI) 35.0-35.9, adult
Z68.36	Body mass index (BMI) 36.0-36.9, adult
Z68.37	Body mass index (BMI) 37.0-37.9, adult
Z68.38	Body mass index (BMI) 38.0-38.9, adult
Z68.39	Body mass index (BMI) 39.0-39.9, adult
Z68.41	Body mass index (BMI) 40.0-44.9, adult
Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.43	Body mass index (BMI) 50-59.9, adult
Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.45	Body mass index (BMI) 70 or greater, adult
Z68.54	Body mass index [BMI] pediatric, greater than or equal to 95th percentile for age [BMI of 40 or greater for adolescents who have completed bone growth]
Z98.84	Bariatric surgery status

References

American Academy of Pediatrics. Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents With Obesity. 2023.

<https://publications.aap.org/pediatrics/article/151/2/e2022060640/190443/Clinical-Practice-Guideline-for-the-Evaluation-and>. Accessed July 15, 2025.

American College of Cardiology/American Heart Association Task Force. Guideline for the Management of Overweight and Obesity in Adults. 2013. <https://www.jacc.org/doi/full/10.1016/j.jacc.2013.11.004>. Accessed July 15, 2025.

American Society of Metabolic and Bariatric Surgery. Updated Position Statement on Sleeve Gastrectomy as a Bariatric Procedure. 2017: <https://asmbs.org/for-healthcare-professionals/>. Accessed July 20, 2023.

Curr Pharm Des. 2011;17(12):1209-17. Bariatric surgery: indications, safety and efficacy. Ben-David K1, Rossidis G.

DeMaria EJ, Portenier D, Wolfe L. Obesity surgery mortality risk score: proposal for a clinically useful score to predict mortality risk in patients undergoing gastric bypass. Surg Obes Relat Dis. 2007 Mar-Apr;3(2):134-40.

National Heart, Lung, and Blood Institute. Managing Overweight and Obesity in Adults. Systematic Evidence Review From the Obesity Expert Panel, 2013. <http://www.nhlbi.nih.gov/sites/www.nhlbi.nih.gov/files/obesity-evidence-review.pdf>. Accessed July 15, 2025.

Scand J Surg. 2015 Mar;104(1):18-23. doi: 10.1177/1457496914552344. Epub 2014 Sep 30. Changing trends in bariatric surgery. Lo Menzo E1, Szomstein S1, Rosenthal RJ2.

Snow V, Barry P, Fitterman N, Qaseem A, Weiss K, for the Clinical Efficacy Assessment Subcommittee of the American College of Physicians. Pharmacological and surgical management of obesity in primary care: a clinical practice guideline from the American College of Physicians. Ann Intern Med. 2005;142:525-531.

Technology Evaluation Center. Newer techniques in bariatric surgery for morbid obesity. Assessment Program. 2003;18(10):1-52.

Technology Evaluation Center. Special report: the relationship between weight loss and changes in morbidity following bariatric surgery for morbid obesity. Assessment Program. 2003;18(9):1-26.

The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES). Guidelines for the Clinical Application of Laparoscopic Bariatric Surgery. 2008: <http://www.sages.org/publications/guidelines/guidelines-for-clinical-application-of-laparoscopic-bariatric-surgery/>. Accessed July 15, 2025.

Kim JJ, Rogers AM, Ballem N, Schirmer B. ASMBS updated position statement on insurance mandated preoperative weight loss requirements. Surgery for Obesity and Related Diseases. 2016;12(5):955-959. doi:10.1016/j.soard.2016.04.019.

Aminian A, Chang J, Brethauer SA, Kim JJ; American Society for Metabolic and Bariatric Surgery Clinical Issues Committee. ASMBS updated position statement on bariatric surgery in class I obesity (BMI 30-35 kg/m(2)). Surg Obes Relat Dis. 2018 Aug;14(8):1071-1087. doi:10.1016/j.soard.2018.05.025. Epub 2018 Jun 9. Review. PubMed PMID: 30061070.

ASGE Standards of Practice Committee (2015). The role of endoscopy in the bariatric surgery patient. *Surgery for Obesity and Related Diseases*, 11(3), 507-517. <https://doi.org/10.1016/j.soard.2015.02.015>. Accessed July 15, 2025.

Hayes inc. Evolving Evidence Review. OverStitch Endoscopic Suturing System (Apollo Endosurgery Inc.) for Transoral Outlet Reduction. Lansdale, PA: Hayes Inc.; July 2022, amended July 2023.

Specialty matched clinical peer review.

Revision History

DATE	REVISION
Jul. 14, 2013	Added SADI-S as covered procedure
Jun. 16, 2023	Clarified that CPT codes 43290 and 42391 are covered for Medicaid and Medicare only

Medical Policy: Bariatric Surgery



Feb. 10, 2023	Added pediatric criteria
Aug. 12, 2022	Added Overstitch device as investigational
Dec. 10, 2021	Added case-by-case consideration language for preoperative esophagogastroduodenoscopy (EGD) for members symptomatic of gastroesophageal reflux disease (GERD)
Feb. 12, 2021	Removed prerequisite for 2 years of insufficient weight loss within Surgical Repetition criteria