BlueCross BlueShield of Vermont

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Bariatric Surgery
Corporate Medical Policy

File name: Bariatric Surgery
File code: 7.01.VT47
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Last Review: 07/2025
Next Review: 07/2026
Effective Date: 01/01/2026 (Adaptive Maintenance Only)

Description/Summary

Bariatric surgery is a treatment for morbid obesity in patients 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.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.

Attachment I- CPT® code table & instructions

General Criteria for Patient Selection and Coverage

Adults

Must meet the following Body Mass Index (BMI) criteria:

- BMI ≥35 kg/m^2; **OR**
- BMI ≥30 kg/m^2 with at least one of the following clinically significant obesity-related complications remediable by weight loss:
  - Diabetes mellitus
  - obstructive sleep apnea
  - coronary artery disease

  - hypertension
  - medical arthropathy
  - nonalcoholic fatty liver disease/nonalcoholic steatohepatitis
  - urinary stress incontinence
  - lower extremity lymphedema or venous obstruction; **OR**
- BMI >27.5kg/m^2 with co-morbidity of diabetes mellitus or metabolic syndrome **AND** of Asian origin

Note: The BMI criterion for bariatric procedures should be adjusted for ethnicity (eg, 18.5 to 22.9 kg/m^2 is normal range, 23 to 24.9 kg/m^2 overweight, and ≥25 kg/m^2 obesity for Asians)

Adolescents (< age 18 years)

Must meet the following criteria:

- Class 3 Obesity (BMI ≥40 kg/m^2 or 140% of the 95th percentile for age and sex, whichever is lower) in adolescents with commonly present, though not required comorbidities**; OR**
- Class 2 Obesity (BMI ≥35 kg/m^2 or 120% of the 95th percentile for age and sex, whichever is lower) in adolescents with clinically significant disease including obstructive sleep apnea (AHI >5), type 2 diabetes, idiopathic intracranial hypertension, nonalcoholic steatohepatitis, Blount disease, slipped capital femoral epiphysis, gastroesophageal reflux disease, **or** hypertension; **AND**
- Does not have a medically correctable cause of obesity (e.g., thyroid or other endocrine disorder); **AND**
- Has attained a score of 4 or 5 on the Tanner Development Scale and is at or near- final adult height; **AND**
- Has failed attempts at non-surgical weight loss (e.g., diet, exercise, medications); **AND**
- Has received psychological or psychiatric evaluation with counseling prior to surgical interventions; **AND**
- Any devices used for bariatric surgery must be used in accordance with the U.S. Food and Drug Administration–approved indications

In addition to the above general criteria, members must meet **ALL** of the following:

- The patient must be at least 18 years of age **or** has attained a score of 4 or 5 on the Tanner Development Scale and is at or near-final adult height.
- Participation in a medically supervised weight loss program within 12 months preceding surgery (may include commercial weight loss programs such as Weight Watchers, Jenny Craig, etc). The medically supervised weight loss attempt(s) must include at least three (3) monthly medical visits under the direction of a medical doctor (MD or DO), physicians' assistant (PA), nurse practitioner (NP) or a registered dietitian supervised by an MD, DO, PA, or NP. The patient's

participation in a structured weight loss regimen must be documented in the medical record by an attending practitioner who supervised the patient's progress. A physician's notation alone is not sufficient documentation. Documentation should include medical records indicating the patient's adherence to the current nutrition and exercise program throughout the course of the medically supervised weight loss regimen. Such documentation is necessary to establish the patient's ability to comply with the dietary and lifestyle changes necessary for maintaining weight loss following surgery.

- Preoperative evaluation by a licensed mental health provider (i.e. psychiatrist, licensed psychologist [PhD or MA] or licensed clinical social worker [LICSW]) to ensure the patient's ability to understand, tolerate and comply with all phases of care and to ensure a commitment to long term follow-up requirements. The evaluation must document that any psychiatric, chemical dependency, or eating disorder contraindication to surgery have been ruled out. Documentation of this evaluation must be included in the request for prior authorization.

  NOTE: Please note that psychiatric evaluation does not require psychological testing. The expectation is that the psychological/psychiatric clearance for bariatric surgery can in most instances be made on the basis of a diagnostic interview using DSM-(the most current version of the DSM) criteria alone and such evaluation does not necessarily require psychological or neuropsychological testing. If psychological or neuropsychological testing is being requested in order to provide psychological/psychiatric clearance for gastric bypass surgery, please note it may be subject to additional prior authorization requirements.

- Completion of appropriate preoperative laboratory studies and EKG, and an appropriate medical work up for associated co-morbidities. A complete physical examination by the attending surgeon and an assessment of thyroid levels is required. If co-morbid conditions are present (i.e. diabetes, GERD or other GI disease, or cardiovascular disease), an appropriate evaluation of those conditions and documentation of the condition and whether or not further workup was required and completed is required to ensure the patient is capable of undergoing the procedure.

When a service may be considered medically necessary

The following bariatric surgery procedures may be considered **medically necessary** for the treatment of morbid obesity (see General Criteria for Patient Selection and Coverage section above) in adults who have failed weight loss by conservative measures:

- Open gastric bypass using a Roux-en-Y anastomosis

- Laparoscopic gastric bypass using a Roux-en-Y anastomosis
- Laparoscopic adjustable gastric banding
- Sleeve gastrectomy
- Open or laparoscopic biliopancreatic bypass (ie, Scopinaro procedure) with duodenal switch.

Bariatric surgery should be performed in appropriately selected patients, by surgeons who are adequately trained and experienced in the specific techniques used, and in institutions that support a comprehensive bariatric surgery program, including long-term monitoring and follow-up post surgery.

Bariatric surgery in adolescents may be considered **medically necessary** (see General Criteria for Patient Selection and Coverage section above), but greater consideration should be given to psychosocial and informed consent issues. In addition, any devices used for bariatric surgery must be used in accordance with the U.S. Food and Drug Administration–approved indications.

Repair of a hiatal hernia at the time of bariatric surgery may be considered **medically necessary** for patients who have a preoperatively diagnosed hiatal hernia with indications for surgical repair.

When a service is considered investigational

The following bariatric surgery procedures are considered **investigational** for the treatment of morbid obesity in adults who have failed weight loss by conservative measures:

- Vertical-banded gastroplasty
- Gastric bypass using a Billroth II type of anastomosis (mini-gastric bypass)
- Biliopancreatic diversion without duodenal switch
- Long-limb gastric bypass procedure (ie, >150 cm)
- Two-stage bariatric surgery procedures (eg, sleeve gastrectomy as initial procedure followed by biliopancreatic diversion at a later time)
- Laparoscopic gastric plication
- Single anastomosis duodenoileal bypass with sleeve gastrectomy.

The following endoscopic procedures are **investigational** as a primary bariatric procedure or as a revision procedure (ie, to treat weight gain after bariatric surgery to remedy large gastric stoma or large gastric pouches):

- Insertion of the StomaphyX™ device
- Endoscopic gastroplasty

- Use of an endoscopically placed duodenojejunal sleeve
- Intragastric balloons
- Aspiration therapy device.

Bariatric surgery is considered **investigational** for the treatment of morbid obesity in preadolescent children.

Repair of a hiatal hernia that is diagnosed at the time of bariatric surgery, or repair of a preoperatively diagnosed hiatal hernia in patients who do not have indications for surgical repair, is considered **investigational**.

The routine use of esophagogastroduodenoscopy with bariatric surgery is considered **investigational.**

REVISION BARIATRIC SURGERY

When a service may be considered medically necessary

Revision surgery to address perioperative or late complications of a bariatric procedure may be considered **medically necessary.** These include, but are not limited to, staple-line failure, obstruction, stricture, and non-absorption resulting in hypoglycemia or malnutrition, weight loss of 20% or more below ideal body weight, and band slippage that cannot be corrected with manipulation or adjustment.

Revision of a primary bariatric procedure that has failed due to dilation of the gastric pouch or dilation proximal to an adjustable gastric band (documented by upper gastrointestinal examination or endoscopy) may be considered **medically necessary** if the initial procedure was successful in inducing weight loss prior to pouch dilation, and the patient has been compliant with a prescribed nutrition and exercise program.

Revision surgery to address severe gastroesophageal reflux disease refractory to medical treatment is considered **medically necessary**.

References Resources

1. Blue Cross Blue Shield Association Medical Policy Reference Manual. Bariatric Surgery. 7.01.47. Last Reviewed January, 2025. Accessed June, 2025.
2. Pediatric Metabolic and Bariatric Surgery: Evidence, Barriers, and Best Practices. Sarah C. Armstrong, Christopher F. Bolling, Marc P. Michalsky, Kirk W. Reichard, SECTION ON OBESITY, SECTION ON SURGERY. Pediatrics Dec 2019, 144 (6) e20193223; DOI: 10.1542/peds.2019-3223

3. Dan Eisenberg et al. 2022 American Society for Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO): Indications for Metabolic and Bariatric Surgery. Surgery for Obesity and Related Diseases 18 (2022) 1345–1356.

Related Policies

Gastric Electrical Stimulation

Sleep Disorders Diagnosis and Treatment

Document Precedence

Blue Cross and Blue Shield of Vermont (Blue Cross VT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, Blue Cross VT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this medical policy. If an audit identifies instances of non-compliance with this medical policy, Blue Cross VT reserves the right to recoup all non- compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be required for services outlined in this policy. Benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

07/31/96	New policy.
08/18/00	Policy updated to include expanded discussion of biliopancreatic bypass and gastric banding. Policy statement unchanged.
05/31/01	Policy revised to include mini-gastric bypass
02/15/02	Policy revised to include further information on laparoscopic banding. Policy statement unchanged.
07/17/03	Policy revised to include the conclusions of the 2003 TEC Assessment. Policy statement added stating laparoscopic gastric bypass is investigational.
11/09/04	Policy revised to include revised CPT® code 43846; no other aspects of policy reviewed at this time. Coding updated in code table.
12/14/05	Policy revised to include the results of the two 2005 TEC Assessments; policy statement regarding laparoscopic gastric bypass changed to medically necessary. Coding updated.
07/20/06	Policy updated with sleeve gastrectomy. Sleeve gastrectomy is considered investigational.

12/12/06	Policy updated with recent TEC Assessment; policy statement changed to indicate that adjustable gastric banding can be considered for those needing bariatric surgery. New references 18 (TEC Assessment) and 41 added. Information added to guidelines section that this policy does not apply to those under the age of 18.
02/14/08	Policy updated with literature review and clinical vetting. Policy statement added that endoscopic procedures for those who regain weight are investigational. Reference numbers 42 to 50 added.
09/16/08	Approved by Clinical Advisory Committee.
03/12/09	Policy update with literature review. Reference numbers 51-87 added. Policy statement added which states that this surgery is investigational as a cure for type 2 diabetes mellitus; statement added that biliopancreatic diversion with duodenal switch may be considered medically necessary; Policy Guidelines updated related to indications for surgery in adolescents and to further clarify definition of morbid obesity. Policy re-titled "Bariatric Surgery."
05/14/09	Policy History for 3/12/09 corrected to say "Policy statement added which states that this surgery is investigational as a cure for type 2 diabetes mellitus".
04/25/13	Additional indication for sleeve gastrectomy added. Policy updated in new format. References updated. Audit information section added. BlueCard clarification added. New Code table added. CPT®-90791 replaces 90801.
06/2015	Medically supervised weight loss program requirement changed from 6 months to 3 months. CPT®- 43774 no longer requires PA.
05/2016	Policy updated with literature review through December 9, 2015. References updated. Single anastomosis duodenoileal bypass with sleeve gastrectomy added as investigational. Added dx codes E66.2, K91.0-K91.3, K95.01, K95.09, K95.81, K95.89, E66.01, E66.09, E66.1, E66.3, E66.8 and E66.9.
06/2018	Policy updated with verbiage clarifying that a psychiatric evaluation is needed, NOT psychological testing, and additional PA may be needed. Moved summary of different surgical procedures to back of policy. Added medical arthropathy and LE lymphedema or venous as co-morbidities with BMI under 35. Clarified member must be of skeletal maturity. Changed weight loss program participation from 2 years to 12 months and clarified that a commercial weight loss program is acceptable. Added language and BMI criteria to address Asian population segment. Added related policy: Sleep Disorders Diagnosis and Treatment. Removed ICD 10-CM table from policy.
06/2020	References reviewed. Policy statements remain unchanged.
05 /2021	Policy reviewed. References reviewed. Updated to reflect BCBSA 7.01.47. Clarify BMI thresholds. Adolescent patient selection criteria updated.
04/2022	Policy reviewed, updated reference no changes to policy statement.
12/2022	Adaptive Maintenance Effective 01/01/2023: Added codes 43290 & 43291 as investigational to the coding table.

05/2023	Policy Reviewed. Updated adult BMI cutoffs as per new guidelines. References updated.
06/2023	Adaptive Maintenance Effective 07/01/2023: Added codes C9784 & C9785 as investigational to coding table.
05/2024	Policy reviewed. Addition of "Revision surgery to address severe gastroesophageal reflux disease refractory to medical treatment is considered medically necessary." Minor formatting changes for clarity and consistency. Reference updated.
07/2025	Policy reviewed. Statement added indicating routine EGD performed with bariatric surgery is considered Investigational. Code 0813T added to coding table as investigational.
12/2025	Adaptive Maintenance Effective 01/01/2026: Added code 43889 to coding table code requires prior approval.

Eligible Providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by Blue Cross VT Medical Director(s)

Tom Weigel, MD, MBA
Vice President & Chief Medical Officer

Tammaji P. Kulkarni, MD
Senior Medical Director

Attachment I

CPT® Code Table & Instructions

Code Type	Number	Description	Policy Instructions
The following codes are considered medically necessary when applicable criteria have been met.			
CPT®	43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	Prior Approval Required
CPT®	43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	Prior Approval Required
CPT®	43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)	Prior Approval Required
CPT®	43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	Prior Approval Required
CPT®	43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	Prior Approval Required
CPT®	43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	Prior Approval Required
CPT®	43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	Prior Approval is Not Required
CPT®	43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)	Prior Approval Required

CPT®	43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	Prior Approval Required
CPT®	43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	Prior Approval Required
CPT®	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)	Prior Approval Required
CPT®	43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	Prior Approval Required
CPT®	43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	Prior Approval Required
CPT®	43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	Prior Approval Required
CPT®	43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	Prior Approval Required
CPT®	43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	Prior Approval Required
CPT®	43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	Prior Approval Required
CPT®	43889	Gastric restrictive procedure, transoral, endoscopic sleeve	Prior Approval Required
CPT®	90791	Psychiatric diagnostic evaluation	Prior Approval is Not Required

HCPCS	S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline.	Prior Approval is Not Required
The following codes will deny as Investigational			
CPT®	0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon	Investigational
CPT®	43290	Esophagogastroduodenoscopy, with deployment of balloon	Investigational
CPT®	43291	Esophagogastroduodenoscopy, with removal of balloon	Investigational
HCPCS	C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty, with esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	Investigational
HCPCS	C9785	Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	Investigational