


MEDICAL POLICY		Bariatric Surgery (Medicare Only)	
Effective Date: 7/1/2020		Section: SUR	Policy No: 139
 <div style="text-align: right;">7/1/2020</div>		Technology Assessment Committee Approved Date: 3/04; 3/05; 3/06; 4/12; 4/16	
		Medical Policy Committee Approved Date: 11/08; 5/09; 7/09; 8/10; 10/10; 10/12; 8/13; 10/13; 3/14; 6/14; 1/15; 11/15; 12/15; 12/16; 1/18; 6/18; 8/19; 3/2020; 8/2020	
Medical Officer	Date		

See Policy CPT CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
<ul style="list-style-type: none"> • <i>Open and Laparoscopic Roux-en-Y gastric bypass (RYGBP)</i> • <i>Open and Laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS)</i> • <i>Gastric Reduction Duodenal Switch (BPD/GRDS)</i> • <i>Laparoscopic adjustable gastric banding (LAGB)</i> • <i>Laparoscopic Sleeve Gastrectomy</i> 	<ul style="list-style-type: none"> • National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Morbid Obesity (100.1)¹ • Local Coverage Article: Bariatric Surgery Coverage (A53028)²

*Per the [Medicare Policy Manual](#) commercial medical policies may be applied to Medicare coverage determinations in the absence of an appropriate NCD, LCD, LCA, or CMS Coverage Manual. Therefore, the commercial medical policy, **Bariatric Surgery (All Lines of Business Except Medicare)**, applies to the following services:*

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- Repeat or revision of bariatric surgery
- Vagus nerve blocking therapy

BILLING GUIDELINES

Only the codes listed on this policy may be used for reporting bariatric procedures. Codes 43631-43634 are specific to gastrectomy and should not be used to report bariatric procedures.

Code 43843 should not be used when there is a procedure-specific bariatric surgery code.

CPT CODES

Medicare Only	
Prior Authorization Required	
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
Roux-en-Y Gastric Bypass	
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
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
Adjustable Gastric Banding (e.g., LAP-BAND®)	
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
Sleeve Gastrectomy	
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)
Biliopancreatic Bypass with Duodenal Switch	
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)
Removal/Revision of Bariatric Surgery	
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only

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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
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
43850	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy
43855	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; with vagotomy
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
Not Covered	
0312T	Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming
0313T	Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator
0316T	Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator
0317T	Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
Unlisted Codes	
All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then prior-authorization is required.	
43659	Unlisted laparoscopy procedure, stomach
43999	Unlisted procedure, stomach

INSTRUCTIONS FOR USE

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Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days' notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

REFERENCES

1. Centers for Medicare & Medicaid Services. National Coverage Determination (NCD) for Bariatric Surgery for Treatment of Morbid Obesity (100.1). 2013; <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=57&ncdver=3&articleId=53028>. Accessed 12/18/2019.
2. Centers for Medicare & Medicaid Services. Local Coverage Article: Bariatric Surgery Coverage (A53028). 2018; <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=53028&ver=33&DocID=A53028>, 12/18/2019.