MEDICAL POLICY

POLICY TITLE	BARIATRIC SURGERY
POLICY NUMBER	MP 1.015

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☐ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective date:	**7/1/2026**

POLICY

Bariatric Surgery in Adults with Class 3 Obesity (BMI ≥40 kg/m^2)

The following bariatric surgery procedures may be considered **medically necessary** for the treatment of class 3 obesity (BMI ≥40.0 kg/m^2) in adults (ages 18 and older) who have failed weight loss by conservative measures:

- Open or laparoscopic gastric bypass using a Roux-en-Y,
- Laparoscopic adjustable gastric banding,
- Open or laparoscopic sleeve gastrectomy (SG), and
- Open or laparoscopic biliopancreatic bypass/diversion (i.e., Scopinaro procedure) with duodenal switch (DS)
- Single anastomosis duodeno-ileal bypass with SG

Bariatric Surgery in Adults with Class 2 Obesity (BMI ≥35 to 39.9 kg/m^2)

The following bariatric surgery procedures may be considered **medically necessary** for the treatment of class 2 obesity in individuals with at least 1 obesity-related comorbid condition (see Policy Guidelines) who have failed weight loss by conservative measures:

- Open or laparoscopic gastric bypass using a Roux-en-Y,
- Laparoscopic adjustable gastric banding,
- Open or laparoscopic sleeve gastrectomy (SG), and
- Open or laparoscopic biliopancreatic bypass/diversion (i.e., Scopinaro procedure) with duodenal switch (DS)
- Single anastomosis duodeno-ileal bypass with SG

Bariatric surgery should be performed in appropriately selected individuals, 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. (see Policy Guidelines for bariatric surgery selection criteria).

Bariatric Surgery in Individuals with Class 1 Obesity (BMI ≥30 to 34.9 kg/m^2) and Type 2 Diabetes

For individuals with Class 1 obesity (BMI ≥30 to 34.9 kg/m^2) and type 2 diabetes, the following bariatric surgery procedures may be considered **medically necessary** in adults who have failed weight loss by conservative measures:

- Open or laparoscopic gastric bypass using a Roux-en-Y,

- Laparoscopic adjustable gastric banding,
- Open or laparoscopic sleeve gastrectomy (SG), and
- Open or laparoscopic biliopancreatic bypass/diversion (i.e., Scopinaro procedure) with duodenal switch (DS)
- Single anastomosis duodeno-ileal bypass with SG

Bariatric surgery is considered **investigational** for individuals with Class 1 obesity who do not have type 2 diabetes. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Bariatric surgery is considered **investigational** for individuals with a BMI less than 30 kg/m^2. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

The following bariatric surgery procedures are considered **investigational** for the treatment of obesity:

- Vertical-banded gastroplasty
- One anastomosis gastric bypass (also known as mini gastric bypass)
- Biliopancreatic diversion (BPD) without DS
- Long-limb gastric bypass procedure (i.e., >150 cm)
- Two-stage bariatric surgery procedures (e.g., SG as initial procedure followed by BPD at a later time)
- Laparoscopic gastric plication, and

Revision Bariatric Surgery

Revision surgery to address perioperative or late complications of a bariatric procedure is considered **medically necessary**. These include but are not limited to, staple line failure, obstruction, stricture, 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 (see Policy Guidelines section).

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) is considered **medically necessary** if the initial procedure was successful in inducing weight loss prior to pouch dilation, and the individual 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**.

Bariatric Surgery in Adolescents

Bariatric surgery in adolescents may be considered **medically necessary** according to similar weight-based criteria used for adults, but greater consideration should be given to psychosocial and informed consent issues (see Policy Guidelines section). In addition, any devices used for

bariatric surgery must be used in accordance with the U.S. Food and Drug Administration approved indications.

Bariatric Surgery in Preadolescent Children

Bariatric surgery is considered **investigational** for the treatment of obesity in preadolescent children. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

Concomitant Hiatal Hernia Repair with Bariatric Surgery

Repair of a hiatal hernia at the time of bariatric surgery may be considered **medically necessary** for individuals who have a preoperatively diagnosed hiatal hernia with indications for surgical repair (see Policy Guidelines section).

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

Endoscopic Procedures

The following endoscopic procedures are **investigational** as a primary bariatric procedure or as a revision procedure (i.e., to treat weight gain after bariatric surgery to remedy large gastric stoma or large gastric pouches) as there is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure:

- Insertion of the StomaphyX™ device,
- Endoscopic gastroplasty,
- Use of an endoscopically placed duodenojejunal sleeve,
- Intragastric balloons, and
- Aspiration therapy device.

Esophagogastroduodenoscopy With Bariatric Surgery

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

POLICY GUIDELINES

Weight-Related Complications

Clinical Practice Guidelines list the following conditions as weight-related complications, defined as conditions caused by or exacerbated by excess adiposity:

- Asthma
- Cardiovascular disease
- Certain types of cancer (e.g., colorectal cancer)
- Type 2 diabetes
- Dyslipidemia
- Gastroesophageal reflux disease (GERD)
- Hypertension

- Infertility
- Male hypogonadism
- Mental health (depression)
- Metabolic syndrome
- Nonalcoholic fatty liver disease (nonalcoholic fatty liver and nonalcoholic steatohepatitis)
- Obstructive sleep apnea
- Osteoarthritis
- Polycystic ovarian syndrome
- Prediabetes
- Stroke
- Urinary stress incontinence

Recommendations specify that bariatric surgery may be considered in individuals with a body mass index (BMI) of ≥35 kg/m^2 and 1 or more severe obesity-related complications, including type 2 diabetes, hypertension, obstructive sleep apnea, obesity-hypoventilation syndrome, Pickwickian syndrome, nonalcoholic fatty liver disease or nonalcoholic steatohepatitis, pseudotumor cerebri, GERD, asthma, venous stasis disease, severe urinary incontinence, debilitating arthritis, or considerably impaired quality of life. However, guidelines do not explicitly define thresholds for determining the clinical significance of obesity-related conditions that would qualify individuals for bariatric surgery.

Bariatric Surgery Selection Criteria

Patients should have documented failure to respond to conservative measures for weight reduction prior to consideration of bariatric surgery, and these attempts should be reviewed by the practitioner prior to seeking approval for the surgical procedure. As a result, some centers require active participation in a formal weight reduction program that includes frequent documentation of weight, dietary regimen, and exercise. However, there is a lack of evidence on the optimal timing, intensity, and duration of nonsurgical attempts at weight loss, and whether a medical weight loss program immediately preceding surgery improves outcomes.

Patients with a BMI of 50 kg/m^2 or more need a bariatric procedure to achieve greater weight loss. Thus, the use of adjustable gastric banding, which results in less weight loss, should be most useful as a procedure for patients with a BMI less than 50 kg/m^2. Malabsorptive procedures, although they produce more dramatic weight loss, potentially result in nutritional complications, and the risks and benefits of these procedures must be carefully weighed in light of the treatment goals for each patient. Patients who undergo adjustable gastric banding and fail to achieve adequate weight loss must show evidence of postoperative compliance with diet and regular bariatric visits prior to consideration of a second bariatric procedure.

Recommendations specify that BMI thresholds for defining obesity do not apply uniformly across all populations. Clinical obesity in the Asian population is identified in individuals with a BMI≥ 25 kg/m^2.

Considerations for Bariatric Surgery in Adolescents

Guidelines for bariatric surgery in adolescents are not uniform, with variability in weight-based criteria, ranging from a BMI of 35 kg/m^2 with comorbidities to a BMI of 50 kg/m^2. Most guidelines use weight-based criteria that parallel those for adults.

In addition to the weight-based criteria, there is greater emphasis on issues of developmental maturity, psychosocial status, and informed consent for adolescent patients. All guidelines mention these issues, but the recommendations are not uniform. The following are examples from U.S. guidelines published since 2013 that address issues of maturity and psychosocial status.

Endocrine Society

- The child has attained Tanner 4 or 5 pubertal development and final or near-final adult height.
- Psychological evaluation confirms the stability and competence of the family unit.
- The patient demonstrates the ability to adhere to the principles of healthy dietary and activity habits (Styne et al, 2017).

Bariatric Procedure Selection for Adolescents

The choice of procedure in adolescents may also differ from adults, but there is a lack of consensus in guidelines or expert opinion as to the preferred procedure(s) for adolescents.

In 2018, the American Society for Metabolic and Bariatric Surgery (ASMBS) published an updated guideline on pediatric metabolic and bariatric surgery (Pratt et al 2018). With regard to choice of procedure, the guideline stated:

- "Vertical sleeve gastrectomy has become the most used and most recommended operation in adolescents with severe obesity for several reasons, near-equivalent weight loss to RYGB [Roux-en-Y gastric bypass] in adolescents, fewer reoperations, better iron absorption, and near-equivalent effect on comorbidities as RYGB in adolescents. However, given the more extensive long-term data available for RYGB, we can recommend the use of either RYGB or VSG in adolescents."

Hiatal Hernia Repair Guidelines

In 2018, the ASMBS and the American Hernia Society published a consensus guideline on bariatric surgery and hernia surgery (Menzo et al, 2018). The guideline contained the following conclusions and summary recommendations:

- "There is a significant link between obesity and hernia formation both after abdominal surgery and de novo. There is also evidence that abdominal wall hernia can more commonly present with obstruction or strangulation in patients with obesity."
- "There is a higher risk for complications and recurrence after hernia repair in patients with obesity."
- "In patients with severe obesity and ventral hernia, and both being amenable to laparoscopic repair, combined hernia repair and metabolic/bariatric surgery may be safe and associated with good short-term outcomes and low risk of infection. There is a relative lack of evidence, however, about the use of synthetic mesh in this setting."

- "In patients with severe obesity and abdominal wall hernia that is not amenable to laparoscopic repair, a staged approach is recommended. Weight loss prior to hernia repair is likely to improve hernia repair outcomes. Metabolic/bariatric surgery appears to provide far more significant and rapid weight loss than other modalities and would be a good option for selected patients with severe obesity and large, symptomatic abdominal wall hernia."

The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) issued evidence-based guidelines for the management of hiatal hernia (Kohn et al, 2013). The Society noted that the general methodologic quality of available studies is low. Recommendations for indications for repair are as follows:

- "Repair of a type I hernia [sliding hiatal hernias, where the gastroesophageal junction migrates above the diaphragm] in the absence of reflux disease is not necessary" (moderate-quality evidence, strong recommendation).
- "All symptomatic paraesophageal hiatal hernias should be repaired [high-quality evidence, strong recommendation], particularly those with acute obstructive symptoms or which have undergone volvulus."
- "Routine elective repair of completely asymptomatic paraesophageal hernias may not always be indicated. Consideration for surgery should include the patient's age and co-morbidities" (moderate-quality evidence, weak recommendation).

Updated guidelines (Daly et al 2024) focused on type II, III, and IV hiatal hernias. Evidence was too weak to make evidence-based recommendations with the exception of the following:

- "The panel suggests patients undergoing repair of a type II, III or IV hiatal hernia may benefit from surgical fundoplication compared to no fundoplication (conditional recommendation, low certainty evidence)."

Esophagogastroduodenoscopy

Preoperative endoscopy with esophagogastroduodenoscopy (EGD) can identify asymptomatic anatomical abnormalities that might influence surgical planning. In 2021, the ASMBS issued a position statement on the rationale for performance of upper gastrointestinal endoscopy before and after bariatric surgery (Campos et al, 2021). The ASMBS recommended preoperative EGD only be performed on patients with symptoms before bariatric surgery. The position statement also noted that while some abnormalities found during EGD do not change medical or surgical management, routine preoperative EGD is justifiable at the surgeon's discretion. Recently, the American Gastroenterological Association (AGA) has published a practice update on performing high-quality upper endoscopy confirming an appropriate indication for EGD, ensuring adequate visualization with mucosal cleansing and insufflation, and using a high-definition white-light endoscopy system (Nagula et al, 2024). The AGA guidance also endorses careful gastric mucosal inspection in anterograde and retroflexed views and documenting abnormalities using established classifications and standard terminology, whenever possible.

Cross-References:
MP 2.045 Diagnosis of Obstructive Sleep Apnea
MP 2.053 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease
MP 2.069 Gastric Electric Stimulation

PRODUCT VARIATIONS

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations. Please see additional information below.

FEP PPO - Refer to FEP medical policy manual. The FEP medical policy manual can be found at: fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

DESCRIPTION/BACKGROUND

Bariatric Surgery

Bariatric surgery is a treatment for 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.

Bariatric surgery is performed to treat obesity and obesity-related comorbid conditions. The first treatment of obesity is dietary and lifestyle changes. Although this strategy may be effective in some patients, only a few individuals with obesity can reduce and control weight through diet and exercise. Most patients find it difficult to comply with these lifestyle modifications on a long-term basis. When conservative measures fail, some patients may consider surgical approaches.

Regulatory Status

Forms of bariatric surgery performed without specific implantable devices are surgical procedures and, as such, are not subject to regulation by the FDA.

Table 1 shows forms of bariatric surgery with implantable devices approved by FDA through the premarket approval process.

Table 1: FDA-Approved Bariatric Surgery Devices

Device	Manufacturer	PMA Date	Labeled Indications
Spatz3 Adjustable Balloon System	Spatz FGIA, Inc.	Oct 2021	For temporary use for weight loss in adults with obesity BMI of 35.0-40.0 kg/m2 or a BMI of 30.0 to 34.9 kg/m2 with one or more major obesity-related comorbid conditions who have failed to achieve and maintain weight-loss with a supervised weight control program. The maximum placement period for Spatz3 Adjustable Balloon System is 8 months.

Obalon™ intra gastric balloon system	Obalon Therapeutics, Inc.	Sept 2016	For use in obese adults (BMI, 30 to 40 kg/m^2) who have failed weight reduction with diet and exercise and have no contraindications. Maximum placement time is 6 mo. Balloon is encased in a capsule. The capsule is swallowed and begins to dissolve after exposure to fluids in the stomach. After verification of capsule placement in the stomach, the balloon is filled with a gas mixture. Up to 3 balloons can be used during the 6-mo treatment period.
AspireAssist System ®	Aspire Bariatrics	Jin 2016	For long-term use in conjunction with lifestyle therapy and continuous medical monitoring in obese adults less than 22 y, with a BMI of 35.0 to 55.0 kg/m^2 and no contraindications to the procedure who have failed to achieve and maintain weight loss with nonsurgical weight loss therapy
ORBERA ® intragastric balloon system	Apollo Endosurgery	Aug 2015	For use in obese adults (BMI, 30-40 kg/m^2) who have failed weight reduction with diet and exercise and have no contraindications. Maximum placement time is 6 mo. Balloon placed endoscopically and inflated with saline.
LAP-BAND® Adjustable Gastric Banding System	Apollo Endosurgery (original applicant: Allergan)	Apr 2010	For use in weight reduction for severely obese adults with BMI of at least 40 kg/m2 or a BMI of at least 30 kg/m2 with ≥1 severe comorbid conditions who have failed more conservative weight-reduction alternatives (e.g., supervised diet, exercise, behavior modification programs).
REALIZE ® Adjustable Gastric Band	Ethicon Endosurgery	Nov 2007	For use in weight reduction for morbidly, obese patients and for individuals with BMI of at least 40 kg/m^2, or a BMI of at least 35 kg/m^2 with greater than or equal to 1 comorbid conditions, or those who are ≥45.4 kg over their estimated ideal weight. Indicated for use only in morbidly obese adults who have failed more conservative weight-reduction alternatives (e.g. supervised diet, exercise, behavior modification programs).

BMI: body mass index: FDA: Food and Drug Administration, PMA: premarket approval.

In February 2017, the FDA issued a letter to health care providers discussing the potential risks with liquid-filled intragastric balloons in response to reports of 2 types of adverse events related to the balloons. Several dozen reports concerned spontaneous overinflation of the balloons,

which caused pain, swelling, and vomiting. The second set of adverse event reports indicated that acute pancreatitis developed in several patients due to compression of gastrointestinal structures. These reports involved both ReShape (no longer marketed in the US) and ORBERA brands. The adverse events may require premature removal of the balloons.

In August 2017, the FDA issued a second letter to health care providers informing them of 5 unanticipated deaths occurring from 2016 through the time of the letter, due to intragastric balloons. The FDA recommended close monitoring of patients receiving these devices. In June 2018, the FDA reported that, since 2016, a total of 12 deaths occurred in patients with liquid-filled intragastric balloons worldwide; 7 of these deaths were in patients in the U.S.

In April 2020, the FDA provided an update on risks and continued to recommend that healthcare providers "instruct patients about the symptoms of life-threatening complications such as balloon deflation, gastrointestinal obstruction, and gastric and esophageal perforation and monitor patients closely during the entire duration of treatment for potential complications, including acute pancreatitis, spontaneous hyperinflation, and other potentially life-threatening complications."

Esophagogastroduodenoscopy

Esophagogastroduodenoscopy (EGD) is useful for detecting conditions that may contraindicate bariatric surgery, such as malignancies. It assists in planning the appropriate bariatric procedure by identifying other gastrointestinal conditions like large hiatus hernia and peptic ulcer, which could impact surgery. EGD also detects conditions needing preoperative treatment, such as Helicobacter pylori infection. Moreover, endoscopy provides an anatomical assessment of the distal stomach, which becomes inaccessible after specific bariatric procedures.

RATIONALE

Summary of Evidence

Adults with Class 3 Obesity

For individuals who are adults (18 years or older) with class 3 obesity (body mass index [BMI] ≥40kg/m2) who are treated with bariatric surgery using open or laparoscopic gastric bypass using a Roux-en-Y, laparoscopic adjustable gastric banding, open or laparoscopic sleeve gastrectomy, open or laparoscopic biliopancreatic bypass/diversion (i.e., Scopinaro procedure) with duodenal switch, or single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S), the evidence includes randomized controlled trials (RCTs), observational studies, and systematic reviews. Relevant outcomes are overall survival (OS), change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Evidence from nonrandomized comparative studies, and meta-analyses of RCTs has consistently reported that bariatric surgery results in substantially greater weight loss than nonsurgical therapy. Data from the largest comparative study (the Swedish Obese Subjects (SOS) study) found that bariatric surgery was associated with improvements in mortality, type 2 diabetes (T2D), cardiovascular risk factors, and quality of life. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Adults with Class 2 Obesity

For individuals who are adults (18 years or older) with class 2 obesity (BMI ≥35 to 39.9 kg/m2) who are treated with bariatric surgery using open or laparoscopic gastric bypass using a Roux-en-Y, laparoscopic adjustable gastric banding, open or laparoscopic sleeve gastrectomy, open or laparoscopic biliopancreatic bypass/diversion (i.e., Scopinaro procedure) with duodenal switch, or SADI-S, the evidence includes RCTs, observational studies, and systematic reviews. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Evidence from nonrandomized comparative studies, and meta-analyses of RCTs has consistently reported that bariatric surgery results in substantially greater weight loss than nonsurgical therapy. Data from the largest comparative study (the SOS study) found that bariatric surgery was associated with improvements in mortality, T2D, cardiovascular risk factors, and quality of life. Additionally, bariatric surgery may greatly reduce the risk of cancer in individuals with obesity and diabetes. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Adults with Class 1 Obesity and Type 2 Diabetes

For individuals who have Class 1 obesity (BMI ≥30 to 34.9 kg/m2) and T2D with bariatric surgery using open or laparoscopic gastric bypass using a Roux-en-Y, laparoscopic adjustable gastric banding, open or laparoscopic sleeve gastrectomy, open or laparoscopic biliopancreatic bypass/diversion (i.e., Scopinaro procedure) with duodenal switch, or SADI-S, the evidence includes systematic reviews of RCTs and observational studies. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Systematic reviews of RCTs and observational studies have found that certain types of bariatric surgery are more efficacious than medical therapy as a treatment for T2D in adults with obesity, including those with a BMI between 30 and 34.9 kg/m2. The greatest amount of evidence assesses gastric bypass, with some comparative studies on LAGB, LSG, and BPD. Systematic reviews have found significantly greater remission rates of diabetes, decrease in HbA1c levels, and decrease in BMI with bariatric surgery than with nonsurgical treatment. The quality of evidence (GRADE) from both RCTs and observational studies for complete diabetes remission and BMI changes was consistently rated as low to very low across various follow-up periods. The efficacy of surgery is balanced against the short-term risks of the surgical procedure. Most RCTs in this population have 1 to 5 years of follow-up data. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Adults with a Body Mass Index <35 kg/m^2 Who Do Not Have Type 2 Diabetes

For individuals with a BMI <35 kg/m^2 who do not have T2D who receive bariatric surgery, the evidence includes systematic reviews of RCTs and observational studies. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. A few small RCTs and case series have reported a loss of weight and improvements in comorbidities for this population. However, the evidence does not permit conclusions on the long-term risk-benefit ratio of bariatric surgery in this population. The

evidence is insufficient to determine that the technology results in an improvement in the net health outcome**.**

Revision Bariatric Surgery

For individuals who are adults who receive revision bariatric surgery, the evidence includes systematic reviews, case series, and registry data. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Systematic reviews and case series have shown that patients receiving revision bariatric surgery experienced satisfactory weight loss and reduced comorbidities including gastroesophageal reflux disease. Data from a multinational bariatric surgery database has found that corrective procedures following primary bariatric surgery are relatively uncommon but generally safe and efficacious. A large retrospective analysis found a serious complication rate of 7.2% for conversion to Roux-en-Y gastric bypass in 13,432 individuals and no difference in 30-day mortality compared to primary Roux-en-Y gastric bypass. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Adolescents with Obesity

For individuals who are adolescent children with obesity who are treated with bariatric surgery using open or laparoscopic gastric bypass, laparoscopic adjustable gastric banding, or open or laparoscopic sleeve gastrectomy, the evidence includes RCTs, observational studies, and systematic reviews. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Systematic reviews of studies on bariatric surgery in adolescents, who mainly received gastric bypass or laparoscopic adjustable gastric banding or sleeve gastrectomy, found significant weight loss and reductions in comorbidity outcomes with bariatric surgery. A single-center small RCT reported significant weight loss and metabolic improvements with laparoscopic adjustable gastric banding compared to conservative treatment. For bariatric surgery in the adolescent population, although data are limited on some procedures, studies have generally reported that weight loss and reduction in risk factors for adolescents are similar to that for adults. Most experts and clinical practice guidelines have recommended that bariatric surgery in adolescents be reserved for individuals with severe comorbidities, or for individuals with a BMI greater than 50 kg/m^2. Also, greater consideration should be placed on the patient developmental stage, on the psychosocial aspects of obesity and surgery, and on ensuring that the patient can provide fully informed consent. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Preadolescent Children with Obesity

For individuals who are preadolescent children with obesity who receive bariatric surgery, there are no studies focused solely on this population. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. No studies have been identified that specifically focus on bariatric surgery in preadolescent children. However, a recent prospective noncomparative cohort study has shown significant, long-term (follow-up of 10 years) weight loss and resolution of comorbidities without safety concerns following LSG in children as young as 5 years old. Additionally, a recent analysis

of surgical outcomes in preteens versus teens, using data from the American College of Surgeons-Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program database, demonstrated that bariatric surgery in preteens is both safe and effective when performed at specialized centers. Nonetheless, further comparative studies are required to draw definitive conclusions about the net health benefits of bariatric surgery in preadolescent children with obesity. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome**.**

Hiatal Hernia Repair with Bariatric Surgery

For individuals with obesity and a preoperative diagnosis of a hiatal hernia who receive hiatal hernia repair with bariatric surgery, the evidence includes a systematic review, cohort studies, and case series. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. A systematic review found that hiatal hernia repair during sleeve gastrectomy was superior to sleeve gastrectomy alone for gastroesophageal reflux disease remission, but not de novo. This combined approach of hernia repair during bariatric surgery has also been shown in a meta-analysis to significantly lower the risk of surgical site infections, reoperations, and seromas. Results from the cohort studies and case series have shown that, when a preoperative diagnosis of a hiatal hernia has been present, repairing the hiatal hernia during bariatric surgery resulted in fewer complications. However, the results are limited to individuals with a preoperative diagnosis. There was no evidence on the use of hiatal hernia repair when the hiatal hernia diagnosis is incidental. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Esophagogastroduodenoscopy with Bariatric Surgery

For Individuals with obesity undergoing bariatric surgery who receive esophagogastroduodenoscopy (EGD), the evidence includes systematic reviews of observational studies. Relevant outcomes are OS, change in disease status, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Current research has focused on pre-operative utility of EGD. The evidence evaluating the scope of EGD in both intraoperative and postoperative settings is lacking in comparison. Systematic reviews have found that only one-fifth of patients had findings from EGD that either altered their operative management or postponed their bariatric surgery. There is a need for direct comparative homogenous studies assessing whether EGD should be routine before bariatric surgery, and whether it is judicious to expose many patients to an invasive procedure that has potential risk and insufficient evidence of effectiveness. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

DEFINITIONS

N/A

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DISCLAIMER

Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as permitted by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These policies are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Investigational; therefore, not covered for bariatric surgery procedures listed as investigational above:

Procedure Codes								
C9785	0813T	43290	43291	43645	43659	43842	43847	43889

Covered when medically necessary:

Procedure Codes								
S2083	43289	43644	43645	43659	43770	43771	43772	43773
43774	43775	43843	43845	43846	43847	43848	43886	43887
43888								

ICD-10-CM Diagnosis Codes	Description
E66.01	Morbid (severe) obesity due to excess calories
K95.09	Other complications of gastric band procedure
K95.89	Other complications of other bariatric procedure
Z46.51	Encounter for fitting and adjustment of gastric lap band
Z68.30	Body mass index [BMI] 30.0-30.9, adult
Z68.31	Body mass index [BMI] 31.0-31.9, adult
Z68.32	Body mass index [BMI] 32.0-32.9, adult
Z68.33	Body mass index [BMI] 33.0-33.9, adult
Z68.34	Body mass index [BMI] 34.0-34.9, adult

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ICD-10-CM Diagnosis Codes	Description
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] 50.0-59.9, adult
Z68.44	Body mass index [BMI] 60.0-69.9, adult
Z68.45	Body mass index [BMI] 70 or greater, adult
Z68.52	Body mass index [BMI] pediatric, 5th percentile to less than 85th percentile for age
Z68.53	Body mass index [BMI] pediatric, 85th percentile to less than 95th percentile for age
Z68.54	Body mass index [BMI] pediatric, greater than or equal to 95th percentile for age
Z98.84	Bariatric surgery status

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POLICY HISTORY

MP 1.015	**05/31/2019 Major Review.** Criteria updated to further define conservative weight loss attempts and pre-operative program. Added smoking and age requirements. References updated. Effective 01/01/2020.
	03/18/2020 Minor Review. Updated criteria to revised BMI requirements, defined requirements for conservative weight loss attempt, removed 6-month program requirement and added requirement for patient participation. References updated. Coding reviewed, no changes. Effective 07/01/2020.
	10/23/2020 Minor Review. Single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S) was added to list of medically necessary bariatric surgeries per ASMBS recommendations. References updated.
	09/29/2021 Minor Review. • Clarified tobacco use to include e-cigarettes or vaped tobacco, marijuana, or other substances. • Time frame for tobacco use changed from 6 months to 6 weeks. • For adults with BMI greater than or equal to thirty-five (35), added cardiovascular heart disease and hepatic steatosis criteria. • Pregnancy avoidance post op changed from 12 months to 12 to 18 months. • Removed timeframe from multi-disciplinary pre-op bariatric surgery program and added that the program should follow guidelines developed by the American Society of Metabolic and Bariatric Surgery. • Clarified mental health professional evaluation purpose • Removed “does not gain weight” from both adult and adolescent requirements during pre-op program. • For adolescents, removed additional criteria surrounding HTN as well as changed NASH to hepatic steatosis without active inflammation. Background and Rationale updated. References added. Updated FEP language added.
	12/01/2022 Administrative Update. Added New Codes 43290 & 43291 Effective 01/01/2023.
	12/20/2022 Minor Review. Title changed to “Metabolic and Bariatric Surgery”. • Adult Criteria o Removed time frame of 2 years for sustainable weight loss o Removed criteria defining sustainable weight loss o BMI criteria for surgery categories changed to BMI > 35 without comorbidities or BMI ≥ 30 with comorbidities listed

	• Adolescent and Children criteria o Children now included in criteria indications o Removed criteria regarding Tanner Developmental Scale o BMI criteria for surgery categories changed to BMI >140% of the 95th percentile (class III obesity/BMI ≥ 40) or BMI > 120% of the 95th percentile (class II obesity/BMI ≥ 35) with obesity related comorbidities listed o Removed time frame for preoperative program o Added contraindications for surgery in adolescents and children • Revisions surgery o Added weight regain and GERD as examples of complications indicating need for revision • Policy Guidelines extensively revised to speak to conservative measure failure, specific guidance for the Asian population, high risk patients and BMI > 50 as well as abdominal wall hernia repair. • ICD 10 codes Z68.30 - Z68.45, Z68.52-Z68.54 added. Background, Rationale and References updated. Product variation and FEP language revised.
	06/13/2023 Administrative Update. Added New Codes C9784 & C9785 Effective 07/01/2023.
	12/12/2023 Administrative Update. Added New Code 0813T. Effective 01/01/2024.
	12/29/2023 Minor Review. Added criteria for escalation surgery. Removed 2 staged procedures from investigational list. Removed criteria for hiatal hernia repair. Background and Rationale updated. References added.
	01/23/2025 Major Review. Title changed from Metabolic and Bariatric Surgery to Bariatric Surgery. Single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S) and 2 stage bariatric surgery changed from medically necessary to investigational. Hiatal hernia repair changed to investigational unless diagnosed preoperatively. Bariatric surgery for preadolescent children changed from medically necessary to investigational. BMI requirements increased and criteria updated to align with BCBSA policy. Added that Esophagogastroduodenoscopy with Bariatric Surgery is investigational. Background, Rationale, References and Cross Referenced Policies updated.
	06/25/2025 Administrative Update. Removed Benefit Variations Section and updated Disclaimer.
	11/05/2025 Consensus review. No change to policy statement.
	12/11/2025 Administrative Update. Added new code 43889. Removed deleted code C9784.. Effective 01/01/2026.
	02/02/2026 Minor Review. SADI-S (Single anastomosis duodeno-ileal bypass with SG) changed from investigational to medically necessary. Policy Guidelines, Cross-Referenced policies, Background, and Rationale updated. References added.

MEDICAL POLICY

POLICY TITLE	BARIATRIC SURGERY
POLICY NUMBER	MP 1.015

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