

Bariatric Surgery and Revision of Bariatric Surgery (Adolescents: Ages 13 - 17)

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Clinical guidelines are applicable according to policy and plan type. The Plan may delegate utilization management decisions of certain services to third parties who may develop and adopt their own clinical criteria.

Coverage of services is subject to the terms, conditions, and limitations of a member's policy, as well as applicable state and federal law. Clinical guidelines are also subject to in-force criteria such as the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) for Medicare Advantage plans. Please refer to the member's policy documents (e.g., Certificate/Evidence of Coverage, Schedule of Benefits, Plan Formulary) or contact the Plan to confirm coverage.

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Summary

Morbid (clinically severe) obesity is a condition in which body fat accumulates to a level that can cause or inhibit the treatment of life-threatening medical comorbidities. Initial treatment steps include a regimented plan of diet and lifestyle changes, often designed and supervised by a team of healthcare professionals. Morbidly obese patients who have failed traditional treatment methods and are being treated for associated high-risk conditions, including diabetes, hypertension, or obstructive sleep apnea, may be candidates for bariatric surgery. Bariatric surgery procedures attempt to reduce fat tissue accumulation through restrictive or malabsorptive approaches and can often be performed as open or laparoscopic surgery. Restrictive surgeries function by decreasing the effective size of the stomach, creating a sensation of early satiety and preventing the patient from consuming large meals. Malabsorptive procedures function by rearranging the flow of food through the digestive system to decrease overall digestion/absorption of calories. Some procedures combine restrictive and malabsorptive approaches. Additionally, a comprehensive post-operative plan of diet, exercise, and behavioral modification is critical in achieving durable weight loss outcomes, where success is defined as a reduction in excess body weight by 50% and returning to within 30% of a patient's ideal body weight. Treatment plans and surgical options differ for adults and adolescents [see CG008: Bariatric Surgery and Revision of Bariatric Surgery (Adults) for patients 18 years or older]. Bariatric surgery always requires prior authorization.

Definitions

"Body mass index (BMI)" relates body weight to height, defined as body mass divided by body height squared in units of kg/m^2 and is used to risk-stratify patients.

"Class I obesity" is defined as a BMI of 30 - 34.9.

"Class II obesity" is defined as a BMI 35 - 39.9.

"Class III obesity" is defined as a BMI ≥ 40 .

"Bariatric" is a term referring to the treatment of obesity.

"Open surgery" refers to a procedure where a large incision allows for direct visualization and access to intra-abdominal organs.

"Endoscopic surgery" is a procedure performed with special cameras and equipment inserted through the mouth and performed inside the stomach or small intestine.

“Laparoscopic surgery” or minimally invasive surgery refers to a procedure often consisting of multiple small incisions allowing the use of a small camera (laparoscope) and several thin instruments.

“Robotic-assisted laparoscopic surgery” is another minimally invasive procedure performed through small incisions. However, a robotic device is used to control the equipment used by the surgeon, who is not at the operating table. Rather, the surgeon sits at a separate console in the same room to perform the surgery inside the body. This type of minimally invasive surgery lets the surgeon see the organs and equipment inside in the body in three dimensions (3D). There are other advantages to both the surgeon and the patient.

“Bariatric surgery” is surgery on the stomach and/or intestines to assist with weight loss in patients with severe or extreme obesity (Classes II and III). Bariatric surgery can be done via restrictive procedures, malabsorptive procedures, or a combination of the two.

- “Restrictive procedures” decrease digestive capacity, promote early satiety, and decrease the speed at which food moves through the digestive system.
 - “Sleeve gastrectomy (SG)” is where the greater curvature of the stomach is resected, resulting in a tube or sleeve-like shape to restrict capacity. This can be performed via open incision or laparoscopically. It can also be combined with malabsorptive surgery at the same time, or in a sequential 2-stage procedure at a later date if adequate weight loss is not obtained.
 - “Endoscopic sleeve gastroplasty (ESG)” is a procedure that uses an endoscope (camera and suturing device inserted through the mouth) to suture the inside of the stomach, reducing its size. This limits the amount of food the stomach can hold.
- “Malabsorptive procedures” reduce digestion and absorption of calories through re-arrangement of the digestive system:
 - “Gastric bypass (Roux-en-Y gastric bypass [RYGB])” combines restrictive and malabsorptive features. The stomach is divided into either a horizontal or vertical plane similar to banded gastropathy (restrictive). The Roux-en-Y procedure then takes the small intestine and creates a “Y” shape, where the two legs of the “Y” allow a portion of food to pass through undigested while retaining a limited digestive capacity for the remaining food (malabsorptive). A gastric bypass can be performed via open incision or laparoscopically. Expected weight loss at two years is approximately 70%.
 - “One anastomosis gastric bypass surgery (OAGB),” also known as “single anastomosis gastric bypass” or “mini-gastric bypass,” combines a sleeve gastrectomy (which reduces stomach size) with a Roux-en Y gastric bypass. In addition to removing excess stomach tissue, this procedure adds a connection to drain the stomach directly into a loop of small intestine that adds a malabsorptive component to the sleeve gastrectomy similar to the Roux-en-Y limb of a gastric bypass. There is only one anastomosis (hook up) between the stomach and the small intestine. This is typically performed as a minimally invasive surgery (laparoscopy or robotic-assisted surgery).

“Repair” refers to a procedure or operation performed to correct and/or treat a complication of a prior surgery.

“Conversion” is when a prior procedure is converted to a new one—such as when there are complications or inadequate weight loss with the primary surgery, or severe gastrointestinal reflux disease (GERD). An example of conversion is a sleeve gastrectomy conversion to Roux-en-Y gastric bypass.

“Revision” refers to a procedure or operation performed due to failure of a desired outcome of the same prior surgery (e.g., the Roux limb is not long enough for weight loss, or a stricture (narrowing) of a prior anastomosis (hook up)).

Medical Necessity Criteria for Clinical Review

General Medical Necessity Criteria

(Please refer to the member’s plan documents for benefits)

Bariatric surgery for adolescents is considered medically necessary when ALL of the following criteria are met:

1. Both patient and parental/guardian informed consent with appropriate explanation of risks, benefits, and alternatives; *and*
2. Adolescent aged 13-17 years who has achieved physical maturity, defined as 95% of the predicted adult stature based on bone age; *or*
3. The presence of obesity with severe comorbidities, defined as ONE of the following:
 - a. BMI \geq 40 or BMI \geq 140% of the 95th percentile for age; *or*
 - b. BMI \geq 35 or BMI \geq 120% of the 95th percentile for age, and any ONE of the following comorbidities:
 - i. Type 2 diabetes mellitus; *or*
 - ii. Moderate to severe sleep apnea (AHI > 15); *or*
 - iii. Pseudotumor cerebri; *or*
 - iv. Severe non-alcoholic steatohepatitis (NASH); *or*
 - v. BMI \geq 30 or BMI \geq 95% to <120% of the 95th percentile for age, see Class I Obesity section below; *and*
4. Failure to achieve and maintain successful long-term weight loss via non-surgical therapy; *and*
5. The proposed bariatric surgery includes a comprehensive pre- and post-operative plan to evaluate nutritional status, overall health, and any specific surgical risks:
 - a. Preoperative evaluation to rule out and treat any other reversible causes of weight gain/obesity, which may include routine lab testing, screenings, and risk evaluations such as:

- i. Fasting blood glucose, fasting lipid panel, complete blood count (CBC), lipid/kidney function testing (complete metabolic panel), blood typing, coagulation studies (PT/PTT/INR); *or*
 - ii. Nutrient deficiency screening (vitamin B12, iron, folate) and formal nutrition evaluation by a registered dietician or nutritionist; *or*
 - iii. Cardiopulmonary risk evaluation - to assess as part of standard pre-operative clearance with EKG, Chest X-Ray, and echocardiogram as appropriate based on medical comorbidities; *or*
 - iv. Endocrine evaluation - Hemoglobin A1c if diabetic, serum TSH if indicated at risk, and appropriate workup of endocrine abnormalities such as Cushing's disease for suspected reversible causes of obesity as part of history and physical
 - v. Smoking cessation counseling, if applicable; *and*
6. Psycho-social behavioral evaluation performed by a licensed adolescent psychologist to specifically assess for ALL of the following:
- a. Member's emotional maturity; *and*
 - b. Member's ability to succeed and adhere to postoperative recommendations and long-term follow up; *and*
 - c. Any major mental health disorders that would contraindicate surgery and/or negatively impact patient compliance with postoperative follow-up care and adherence to nutrition guidelines; *and*
 - d. No current substance abuse has been identified; *and*
 - e. If applicable, members who have any ONE of the following conditions MUST also have formal, documented preoperative clearance by a licensed psychiatrist:
 - i. A history of schizophrenia, borderline personality disorder, suicidal ideation, or severe depression; *or*
 - ii. Currently under the care of a psychologist or psychiatrist; *or*
 - iii. Currently on psychotropic medications, in order to exclude members who are unable to provide informed consent or who are unable to comply with the pre- and post-operative regimen.

Indication-Specific Criteria

Members with Class I Obesity (BMI 30-34.9 or BMI ≥95% to <120% of the 95th percentile for age)
(Please refer to the member's plan documents for benefits)

The Plan will consider bariatric surgery on a case-by-case basis in adolescents with BMI 30-34.9 or BMI ≥95% to <120% of the 95th percentile for age when ALL of the following are met:

1. Member meets all criteria listed above under General Medical Necessity Criteria; *and*
2. Type 2 diabetes with poorly controlled hyperglycemia despite optimal lifestyle and medical therapy by either oral or injectable medications, including insulin; *and*
3. Consideration of the member's clinical appropriateness for bariatric surgery on a case-by-case basis upon medical review.

Repair of Primary Bariatric Surgery

(Please refer to the member's plan documents for benefits)

The Plan considers repair of a primary bariatric surgery medically necessary when there is documentation of ONE of the following surgical complications related to the original surgery:

1. Fistula; *or*
2. Erosion; *or*
3. Leakage of suture/staple line; *or*
4. Herniated band; *or*
5. Obstruction; *or*
6. Enlargement of the pouch due to complications of vomiting.
 - a. Note: Enlargement of pouch (stretching) is NOT covered if due to overeating, as this is not a surgical complication and is therefore not considered medically necessary.

Removal of Adjustable Gastric Band

(Please refer to the member's plan documents for benefits)

The Plan may consider removal of an adjustable gastric band medically necessary when ONE of the following criteria is met:

1. Recommended by the member's physician.

Revision of Primary Bariatric Surgery

(Please refer to the member's plan documents for benefits)

The Plan considers revision of a primary bariatric surgery medically necessary when ALL of the following criteria are met:

1. The procedure has failed due to dilated gastrojejunal stoma, dilation of the anastomosis site, or dilation of the gastric pouch; *and*
2. The initial surgery successfully resulted in weight loss; *and*
3. The member has been compliant with the postoperative plan of diet, exercise, and behavioral modification.

Conversion Procedures for Inadequate Weight Loss

(Please refer to the member's plan documents for benefits)

The Plan considers conversion surgery to a sleeve gastrectomy or Roux-en-Y gastric bypass (RYGB) medically necessary when there are complications that cannot be corrected and ALL of the following criteria are met:

1. General Medical Necessity Criteria are met; *and*
2. Documented compliance with postoperative plan of diet, exercise, and behavioral modification; *and*
3. A minimum of 2 years following original surgery with documentation of inadequate weight loss, defined as BOTH of the following:
 - a. Weight loss of less than 50% of preoperative *excess* body weight; *and*
 - b. Remains >30% over ideal body weight.

Conversion Procedures for Non-Weight Loss Indications

(Please refer to the member's plan documents for benefits)

The Plan considers conversion surgery from a sleeve gastrectomy to a Roux-en-Y gastric bypass (RYGB) medically necessary for *proton pump inhibitor (PPI)-refractory gastroesophageal reflux disease (GERD), Barrett's esophagus, or biopsy-proven dysplasia*, when ONE of the following criteria is met:

1. A biopsy documented Barrett's esophagus with high grade dysplasia (cancer risk 7% per year) confirmed by two separate pathologists refractory to maximal medical and endoscopic therapy;
or
2. A biopsy documented Barrett's esophagus with low grade dysplasia (cancer risk 0.7% per year) confirmed by two separate pathologists refractory to maximal medical therapy, including ALL of the following:
 - a. At least 3 months of prescription strength anti-secretory agents (e.g., omeprazole, pantoprazole, esomeprazole, etc.); *and*
 - b. At least 3 months of ONE of the following (unless contraindicated):
 - i. Aspirin, nonsteroidal anti-inflammatory agents, or statins (HMG-CoA reductase inhibitors); *and*
 - c. Failure of endoscopic therapy; *or*
3. A biopsy-proven non-dysplastic or indefinite grade dysplasia confirmed by two separate pathologists that has progressed to biopsy-proven dysplasia despite at least 1 year of maximal medical therapy as described above; *or*
4. PPI-refractory gastroesophageal reflux disease (GERD) meeting ALL of the following:
 - a. Failure of at least 1 year of single dose prescription strength (not over the counter) anti-secretory treatment (e.g., PPI); *and*
 - b. At least 8 weeks of dual prescription strength anti-secretory treatment (2 different PPIs taken together); *and*
 - c. Biopsy-proven erosive disease confirmed by separate two pathologists (e.g., esophagitis Los Angeles (LA) Grade C or D, peptic stricture requiring dilatation, Barrett's esophagus as described above); *and*
 - d. ONE of the following:
 - i. Failure of endoscopic therapy; *or*
 - ii. Failure of prior surgical therapy (e.g., surgical fundoplication, hiatal hernia repair, vagotomy).

Length of Stay

Length of Stay Initial Clinical Review

The Plan considers the following procedures, settings, and goal lengths of stay for the treatment of morbid obesity in adolescents (ages 13-17) medically necessary when ONE of the following criteria is met:

1. Roux-en-Y gastric bypass (<150cm), when ONE of the following is met:
 - a. Open - 2-day inpatient admission; *or*

- b. Laparoscopic - Ambulatory, which may include an overnight stay; *or*
 - c. Laparoscopic - Inpatient admission, when MCG Ambulatory Surgery Exception Criteria (CG-AEC) are met; *or*
2. Sleeve gastrectomy, when ONE of the following is met:
- a. Open - 1-day inpatient admission; *or*
 - b. Laparoscopic - Ambulatory, which may include an overnight stay; *or*
 - c. Laparoscopic - Inpatient admission, when MCG Ambulatory Surgery Exception Criteria (CG-AEC) are met.

Length of Stay Subsequent Clinical Review

Subject to medical necessity review, the Plan may consider extensions for hospital admission when ONE of the following criteria is met:

1. Patients <18 years old; *or*
2. In the presence of complex comorbidities (COPD, renal disease, heart failure, etc.); *or*
3. Conversion from laparoscopic to open procedure; *or*
4. Complications in the peri- or post-operative phases, such as anastomotic leak, thromboembolic disease (DVT or pulmonary embolism), wound infection, suture line bleeding, pneumonia, respiratory failure, evisceration, or splenic injury; *or*
5. Clear liquid diet not tolerated during the postoperative phase; *or*
6. Failure to meet general discharge criteria per MCG guidelines.

Experimental or Investigational / Not Medically Necessary

Procedures

Although the following may be medically necessary in adults meeting the appropriate criteria, there is a lack of clinical evidence and/or long-term data for the following procedures in morbidly obese adolescents:

1. Laparoscopic adjustable gastric banding
2. Biliopancreatic diversion with duodenal switch (open or laparoscopic)

The Plan considers the following procedures to be experimental, investigational, or unproven as they have either not demonstrated long-term benefit, have unnecessary risks, or have demonstrated inferior outcomes to safer, more appropriate techniques:

1. >150cm long limb gastric bypass (except for BPD with DS)
2. Air-filled intragastric balloon or liquid-filled intragastric balloons (e.g., Orbera, ReShape)
3. Aspiration therapy procedures
4. Biliopancreatic diversion (BPD) without duodenal switch
5. Conversion of gastric sleeve to Roux-en-Y gastric bypass for gastroparesis
6. Gastroplasty (stomach stapling)
7. Gastric plication (laparoscopic)
8. Endoscopic sleeve gastroplasty (ESG)
9. Endoluminal vertical gastroplasty

10. Jejunioileal bypass
11. Mini gastric bypass/one anastomosis gastric bypass/Billroth II
12. Natural orifice transoral surgery (NOTES)
13. Open adjustable gastric banding
14. Prophylactic mesh placement to prevent incisional hernia after open bariatric surgery
15. Silastic ring (Fobi pouch)
16. Vagal blockade (vagus nerve blocking therapy)
17. Vertical banded gastroplasty (VBG)

Skin Removal Surgery

Excess skin is common after a successful bariatric surgery. Unless MCG criteria are met, the Plan considers skin removal by abdominoplasty and/or panniculectomy a cosmetic and elective procedure that is not medically necessary.

General Contraindications

1. Medically correctable cause of obesity
2. Ongoing substance abuse or substance abuse in preceding 12 months
3. Medical, psychological, psychosocial, or cognitive condition that prevents adherence to post-op dietary and medical requirements or impairs decision capacity
4. Current or planned pregnancy within 12-18 months
5. Inability of patient or parent to comprehend risks, benefits, and alternatives of surgical procedure
6. Severe or poorly controlled psychiatric disorder or mental illness, as above
7. Bulimia nervosa
8. Any advanced stage neoplastic disease
9. Diagnosis of inflammatory bowel disease
10. Any medical condition requiring critical drug levels, such as in seizure or psychiatric illness, where malabsorption or changes in drug metabolism may result in serious consequences.

Applicable Billing Codes

Table 1	
CPT/HCPCS codes considered medically necessary if criteria are met:	
<i>Code</i>	<i>Description</i>
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)

Table 1	
CPT/HCPCS codes considered medically necessary if criteria are met:	
<i>Code</i>	<i>Description</i>
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)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
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
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
47562	Laparoscopy, surgical; cholecystectomy
47563	Laparoscopy, surgical; cholecystectomy with cholangiography
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct
47570	Laparoscopy, surgical; cholecystoenterostomy
47579	Unlisted laparoscopy procedure, biliary tract <ul style="list-style-type: none"> • <u>Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below:</u> • When this code is billed in conjunction with an approved primary procedure for weight loss, then it is considered medically necessary if no other more specific biliary tract CPT is appropriate.
47600	Cholecystectomy
47605	Cholecystectomy; with cholangiography

Table 1	
CPT/HCPCS codes considered medically necessary if criteria are met:	
<i>Code</i>	<i>Description</i>
47610	Cholecystectomy with exploration of common duct
47612	Cholecystectomy with exploration of common duct; with choledochoenterostomy
47620	Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography
S9449	Weight management classes, non-physician provider, per session
S9451	Exercise classes, non-physician provider, per session
S9452	Nutrition classes, non-physician provider, per session

Table 2	
ICD-10 codes considered medically necessary with Table 1 codes if criteria are met:	
<i>Code</i>	<i>Description</i>
E66.01	Morbid (severe) obesity due to excess calories
E66.2	Morbid (severe) obesity with alveolar hypoventilation
Z68.54	Body mass index (BMI) pediatric, 95th percentile for age to less than 120% of the 95th percentile for age
Z68.55	Body mass index [BMI] pediatric, 120% of the 95th percentile for age to less than 140% of the 95th percentile for age
Z68.56	Body mass index [BMI] pediatric, greater than or equal to 140% of the 95th percentile for age

Table 3	
CPT/HCPCS codes that may be considered medically necessary for requests related to conversion surgery from a sleeve gastrectomy to a Roux-en-Y gastric bypass:	
<i>Code</i>	<i>Description</i>
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)

Table 4	
CPT/HCPCS codes <u>not considered medically necessary</u> for requests related to conversion surgery from a sleeve gastrectomy to a Roux-en-Y gastric bypass:	
<i>Code</i>	<i>Description</i>
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh
43620	Gastrectomy, total; with esophagoenterostomy
43621	Gastrectomy, total; with Roux-en-Y reconstruction
43632	Gastrectomy, partial, distal; with gastrojejunostomy
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction
43634	Gastrectomy, partial, distal; with formation of intestinal pouch
43820	Gastrojejunostomy; without vagotomy
43825	Gastrojejunostomy; with vagotomy, any type

Table 5	
CPT/HCPCS codes <u>not</u> applicable to the bariatric surgery criteria in this guideline:	
<i>Code</i>	<i>Description</i>
15876	Suction assisted lipectomy; head and neck

Table 5	
CPT/HCPCS codes <u>not</u> applicable to the bariatric surgery criteria in this guideline:	
<i>Code</i>	<i>Description</i>
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
43620	Gastrectomy, total; with esophagoenterostomy
43621	Gastrectomy, total; with Roux-en-Y reconstruction
43622	Gastrectomy, total; with formation of intestinal pouch, any type
43631	Gastrectomy, partial, distal; with gastroduodenostomy
43632	Gastrectomy, partial, distal; with gastrojejunostomy
43632	Gastrectomy, partial distal; with gastrojejunostomy
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction
43634	Gastrectomy, partial, distal; with formation of intestinal pouch
43635	Vagotomy when performed with partial distal gastrectomy (List separately in addition to code(s) for primary procedure)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
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
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty

Table 5	
CPT/HCPCS codes <u>not</u> applicable to the bariatric surgery criteria in this guideline:	
<i>Code</i>	<i>Description</i>
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)
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline

Table 6	
CPT/HCPCS codes considered experimental, investigational, or unproven for indications in this guideline:	
<i>Code</i>	<i>Description</i>
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)
43659	Unlisted laparoscopy procedure, stomach

Table 6	
CPT/HCPCS codes considered experimental, investigational, or unproven for indications in this guideline:	
<i>Code</i>	<i>Description</i>
	<ul style="list-style-type: none"> • <u>Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below:</u> • When this code is billed for gastric plication (laparoscopic greater curvature plication [LGCP]) with or without gastric banding, or mini-gastric bypass procedure), it is considered experimental or investigational
43889	Gastric restrictive procedure, transoral, endoscopic sleeve gastroplasty (ESG), including argon plasma coagulation, when performed
43999	Unlisted procedure, stomach <ul style="list-style-type: none"> • <u>Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below:</u> • When this code is billed for endoscopic or endoluminal gastric restrictive procedures, or for placement of an intragastric balloon device, it is considered experimental or investigational
64999	Unlisted procedure, nervous system <ul style="list-style-type: none"> • <u>Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below:</u> • When this code is billed for vagus nerve blocking therapy for the purpose of weight loss, it is considered experimental or investigational

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