Priority Health	BILLING POLICY No. 137

BARIATRIC SURGERY FOR TREATMENT OF CO-MORBIDITIES CONDITIONS RELATED TO MORBID OBESITY

Date of origin: Aug. 2025	Review dates: 08/2026

POLICY OVERVIEW

This policy provides guidelines for billing, coding, documentation, and ensuring claims are processed according to contractual and industry standards. Bariatric surgery is a treatment for obesity in patients who fail to lose weight with conservative measures. The first and best treatment of obesity is dietary and lifestyle changes. Although this strategy may be effective in some members, only a few individuals with obesity can reduce and control weight through diet and exercise. When conservative measures fail, some members may consider surgical approaches.

DEFINITIONS

Bariatric surgery includes procedures designed to help patients with severe obesity achieve significant weight loss by altering the digestive system. Typical candidates have a BMI ≥40, or BMI ≥35 with serious comorbidities such as Type 2 diabetes, hypertension, or sleep apnea. Common procedures include Laparoscopic Sleeve Gastrectomy (LSG), Roux-en-Y Gastric Bypass (RYGB), Adjustable Gastric Banding, and Biliopancreatic Diversion with Duodenal Switch (BPD/DS).

Endoscopic sleeve gastroplasty (ESG) - ESG uses an endoscopic suturing device to seal off most of the stomach, forcing ingested food through an open tube of stomach tissue that connects the esophagus to the small intestine. ESG reduces the capacity of the stomach, which induces satiety with lower food consumption, thereby achieving weight loss. Unlike conventional open or laparoscopic surgeries, in ESG, the excess stomach tissue is not surgically removed. Additional terms for ESG include accordion procedure, transoral gastroplasty, vertical sutured gastroplasty, and endoluminal vertical gastroplasty.

MEDICAL POLICY

Surgical Treatment of Obesity - 91595

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Coding Specifics

Table below includes billable CPT/HCPCS codes for Bariatric Surgery:

CPT/HCPSC Code	Description
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption

43659	Unlisted laparoscopy procedure, stomach (when billed for SADI-S)
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric band component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric band component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band and subcutaneous port components
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric band (separate procedure)
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
43889	Gastric restrictive procedure, transoral, endoscopic sleeve gastroplasty (ESG), including argon plasma coagulation, when performed (Effective 1/1/2026)
43999	Unlisted procedure, stomach (Explanatory notes must accompany claim) Use this code for billing: Open sleeve gastrectomy
C9785	Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Diagnosis

Claims for any bariatric surgical procedure must include the following diagnoses:

- 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

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to procedure; diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
08/11/2026	Added CPT codes in the formatted table.