Surgical Procedures

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➲ Instructions for Use

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Coverage Rationale

Note: The medical necessity criteria referenced in this Medicare Advantage Medical Policy applies to a surgical procedure regardless of the approach, unless noted otherwise.

Bariatric Surgery

Medicare does have an National Coverage Determinations (NCD) for bariatric surgery. Refer to the NCD for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (100.1) for coverage guidelines. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Bariatric Surgical Management of Morbid Obesity.

For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Bariatric Surgery for utilization guidelines for all other procedures not listed as nationally non-covered in the NCD for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (100.1).

Note: When the NCD or LCDs/LCAs is silent on coverage criteria for bariatric procedures [including revisions, staged procedures, or various surgical approaches (e.g., endoscopic approach)], refer to the UnitedHealthcare Commercial Medical Policy titled Bariatric Surgery for clinical coverage guidance.

Bronchial Thermoplasty

Medicare does not have an NCD for bronchial thermoplasty. LCDs/LCAs do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Bronchial Thermoplasty.

Hiatal Hernia Repair

Medicare does not have an NCD for hiatal hernia repair. LCDs/LCAs do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Antireflux Surgery or Hiatal Hernia Repair.

Click here to view the InterQual® criteria.

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Implantation of Glaucoma Drainage Devices

Medicare does not have an NCD for the implantation of glaucoma drainage devices. LCDs/LCAs do not exist for implantation of glaucoma drainage devices for CPT code 66180.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Glaucoma Surgical Treatments.

Lymphedema Surgical Treatments

Medicare does not have an NCD for lymphedema surgical treatments. LCDs/LCAs do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Surgery for the Prevention and Treatment of Lymphedema.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
Bariatric Surgery	
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)
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
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
43659	Unlisted laparoscopy procedure, stomach
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
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 (i.e., sleeve gastrectomy)
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)
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

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CPT Code	Description
Bariatric Surgery	
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
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
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open
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
43999	Unlisted procedure, stomach
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array
64999	Unlisted procedure, nervous system
Bronchial Thermoplasty	
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe [Refer to the UnitedHealthcare Commercial Medical Policy titled Bronchial Thermoplasty]
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes [Refer to the UnitedHealthcare Commercial Medical Policy titled Bronchial Thermoplasty]
Hiatal Hernia Repair	
43499	Unlisted procedure, esophagus
Implantation of Glaucoma Drainage Devices	
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft
Lymphedema Surgical Treatments	
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity

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CPT Code	Description
Lymphedema Surgical Treatments	
15879	Suction assisted lipectomy; lower extremity
38999	Unlisted procedure, hemic or lymphatic system [when used to report lymphedema surgical treatments]

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD, or LCA is found, refer to the criteria as noted in the Coverage Rationale section above.

NCD	LCD	LCA	Contractor Type	Contractor Name
Bariatric Surgical Management of Morbid Obesity				
100.1 Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity	L33411 Surgical Management of Morbid Obesity	A57145 Billing and Coding: Surgical Management of Morbid Obesity	Part A and B MAC	First Coast
	N/A	A52447 Laparoscopic Sleeve Gastrectomy (LSG) – Medical Policy Article	Part A and B MAC	NGS
	N/A	A53026 Billing and Coding: Bariatric Surgery Coverage	Part A and B MAC	Noridian
	N/A	A53028 Billing and Coding: Bariatric Surgery Coverage **Retired 9/25/2025**	Part A and B MAC	Noridian
	L35022 Bariatric Surgical Management of Morbid Obesity	A56422 Billing and Coding: Bariatric Surgical Management of Morbid Obesity	Part A and B MAC	Novitas**
	L34576 Laparoscopic Sleeve Gastrectomy for Severe Obesity	A56852 Billing and Coding: Laparoscopic Sleeve Gastrectomy for Severe Obesity	Part A and B MAC	Palmetto**
	N/A	A53444 Billing and Coding: Periodic Adjustment of Gastric Restrictive Device after the Global Period	Part A and B MAC	Palmetto**
	N/A	A54923 Billing and Coding: Bariatric Surgery for Treatment of Co-Morbidities Conditions Related to Morbid Obesity	Part A and B MAC	WPS*

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE

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Medicare Administrative Contractor (MAC) With Corresponding States/Territories
Notes
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.

Policy History/Revision Information

Date	Summary of Changes

03/01/2026	**Related Policies**
	• Added reference link to the UnitedHealthcare Medicare Advantage Reimbursement policy titled:
	  ○ *Add-on Codes Policy, Professional*
	  ○ *Global Days Policy, Professional*
	Centers for Medicare and Medicaid Services (CMS) Related Documents
	• Updated list of documents available in the *Medicare Coverage Database* to reflect the most current information
	Supporting Information
	• Archived previous policy version MMP108.08

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a

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result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.

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