

Bariatric Surgery (for Louisiana Only)

Retired April 1, 2026

Policy Number: CS007LA1.E

Effective Date: April 1, 2025 – March 31, 2026

[Instructions for Use](#)

Content mandated by Louisiana Department of Health

Table of Contents	Page
Application	1
Coverage Rationale	1
Applicable Codes	2
References	3
Policy History/Revision Information	3
Instructions for Use	4

Application

This Medical Policy only applies to the state of Louisiana. The coverage rationale contained in this policy represents Louisiana Medicaid coverage policy and is set forth below in accordance with State requirements.

Coverage Rationale

Louisiana Medicaid covers bariatric surgery, consisting of open or laparoscopic procedures that revise the gastrointestinal anatomy to restrict the size of the stomach, reduce absorption of nutrients, or both.

Eligibility Criteria

To be eligible for bariatric surgery, beneficiaries must meet the following criteria:

- Received a preoperative evaluation within the previous 12 months that is conducted by a multidisciplinary team including, at a minimum, a physician, nutritionist or dietician, and a licensed qualified mental health professional. For beneficiaries under the age of 18, the multidisciplinary team must have pediatric expertise. For all beneficiaries, the preoperative evaluation must document all of the following:
 - A determination that previous attempt(s) at weight loss have been unsuccessful and that future attempts, other than bariatric surgery, are not likely to be successful; and
 - A determination that the beneficiary is capable of adhering to the post-surgery diet and follow-up care; and
 - For individuals capable of becoming pregnant, counseling to avoid pregnancy preoperatively and for at least 12 months postoperatively and until weight has stabilized
 - Beneficiaries age 18 and older must meet the following criteria:
 - A body mass index equal to or greater than 40 kg/m², or more than 100 pounds overweight; or
 - A body mass index of greater or equal to 35 kg/m² with one or more of the following comorbidities related to obesity:
 - Type 2 diabetes mellitus; or
 - Cardiovascular disease (e.g., stroke, myocardial infarction, poorly controlled hypertension (systemic blood pressure greater than 140 mm hg or diastolic blood pressure 90 mm hg or greater, despite pharmacotherapy); or
 - History of coronary artery disease with a surgical intervention such as coronary artery bypass or percutaneous transluminal coronary angioplasty; or
 - History of cardiomyopathy; or
 - Obstructive sleep apnea confirmed on polysomnography with an AHI or RDI of ≥ 30; or
 - Any other comorbidity related to obesity that is determined by the preoperative evaluation to be improved by weight loss
- or

- A body mass index of 30 to 34.9 kg/m² with type 2 diabetes mellitus if hyperglycemia is inadequately controlled despite optimal medical control by oral or injectable medications
- Beneficiaries age 13 through 17 years old must have:
 - A body mass index equal to or greater than 40 kg/m² or 140% of the 95th percentile for age and sex, whichever is lower; or
 - A body mass index of 35 to 39.9 kg/m² or 120% of the 95th percentile for age and sex, whichever is lower, with one or more comorbidities related to obesity:
 - Obstructive sleep apnea confirmed on polysomnography with an AHI > 5; or
 - Type 2 diabetes mellitus; or
 - Idiopathic intracranial hypertension; or
 - Nonalcoholic steatohepatitis; or
 - Blount's disease; or
 - Slipped capital femoral epiphysis; or
 - Gastroesophageal reflux disease; or
 - Hypertension; or
 - Any other comorbidity related to obesity that is determined by the preoperative evaluation to be improved by weight loss
- Requests for beneficiaries under the age of 13 will be reviewed for medical necessity on a case-by-case basis

Prior Authorization

Coverage of bariatric surgery requires prior authorization.

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. Benefit coverage for health services is determined by federal, state, or contractual requirements 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.

Coding Clarification: Utilize CPT code 43775 to report laparoscopic sleeve gastrectomy rather than the unlisted CPT code 43659.

CPT Code	Description
*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)
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

CPT Code	Description
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
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
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

CPT® is a registered trademark of the American Medical Association

Codes labeled with an asterisk (*) are not on the State of Louisiana Medicaid Fee Schedule and therefore may not be covered by the State of Louisiana Medicaid Program.

References

Louisiana Department of Health: Professional Services Provider Manual, Section 5.1 of the Medicaid Services Manual: Bariatric Surgery. <https://www.lamedicaid.com/provweb1/providermanuals/manuals/PS/PS.pdf>. Accessed Dec 2, 2024.

Policy History/Revision Information

Date	Summary of Changes
04/01/2026	<ul style="list-style-type: none"> Retired policy; Louisiana plan membership disenrolled on Apr. 1, 2026
04/01/2025	<p>Applicable Codes</p> <ul style="list-style-type: none"> Added CPT code 43999 Added notation to indicate CPT code 0813T is not on the State of Louisiana Medicaid Fee Schedule and therefore may not be covered by the State of Louisiana Medicaid Program Removed notation indicating CPT code 64595 is not on the State of Louisiana Medicaid Fee Schedule and therefore may not be covered by the State of Louisiana Medicaid Program <p>Supporting Information</p> <ul style="list-style-type: none"> Archived previous policy version CS007LA1.D

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual[®] criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.