January 28, 2026

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Aetna
261 N. University Drive
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**Re: Obesity Surgery Clinical Policy Bulletin Number 0157**

Dear Dr. Freedman,

Thank you for allowing the American College of Gastroenterology, the American Gastroenterological Association, and the American Society for Gastrointestinal Endoscopy the opportunity to provide feedback on the Aetna Obesity Surgery Clinical Policy Bulletin Number 0157. Together, our societies represent virtually all practicing gastroenterologists in the United States. We appreciate Aetna's willingness to consider our feedback in preparation for the next review of policy bulletin 0157 on February 12, 2026.

**New CPT code 43889**

We'd like to bring to Aetna's attention the new Category I Current Procedural Terminology (CPT) code 43889 (*Gastric restrictive procedure, transoral, endoscopic sleeve gastroplasty (ESG), including argon plasma coagulation, when performed*) to report transoral endoscopic sleeve gastroplasty effective January 1, 2026. CPT code 43889 is located in the "Other Procedures" section following bariatric surgery codes of the American Medical Association (AMA) 2026 CPT manual. As you may be aware, the AMA has stringent criteria for Category I CPT codes. Code 43889 met or exceeded each criteria, including clinical efficacy of the procedure documented in literature that meets the requirements set forth in the CPT code-change application.

Please note that Aetna included in policy bulletin 0157 the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) Bariatric Endoscopy Committee's evidence-based review and position statement on ESG[1] and the ASGE-European Society of

[1] https://pubmed.ncbi.nlm.nih.gov/39482444/

Gastrointestinal Endoscopy (ESGE) guideline on primary endoscopic bariatric and metabolic therapies for adults with obesity[2] which indicate moderate quality of evidence based on randomized controlled trials and support coverage of ESG. Additionally, policy bulletin 0157 quoted durability at 5 years, "Abu Dayyeh and colleagues showed its durability on the basis of weight loss outcomes." Lastly, the American Society for Metabolic and Bariatric Surgery (ASMBS) endorsed[3] ESG as a safe, effective, and evidence-based intervention for the treatment of metabolic and bariatric disease, reflecting the current clinical best practice.

Based on the AMA's creation of Category I CPT code 43889 effective January 1, 2026, the IFSO position statement, ASGE-ESGE guideline, and ASMBS endorsement, **we recommend Aenta add CPT code 43889 to its list of covered procedures in policy bulletin 0157**.

**New nomenclature for NASH/NAFLD**

Aetna may already be aware of new nomenclature for non-alcoholic steatohepatitis (NASH) and non-alcoholic fatty liver disease (NAFLD)[4]. **We recommend updating occurrences of NASH and NAFLD to metabolic dysfunction-associated steatohepatitis (MASH) and metabolic dysfunction-associated steatotic liver disease (MASLD) respectively for consistency with current clinical nomenclature**.

**General feedback on policy bulletin 0157**

Overall, many of the endorsed bariatric surgeries based on National Institute of Health (NIH) guidelines or studies for bariatric surgery are based on less or equal certainty data than the endoscopic ones. Additionally, there is a large body of data that discusses weight recurrence after bariatric surgery being prevalent. Obesity is a chronic relapsing, remitting disease that very frequently will need multiple interventions in a lifetime to keep it controlled. Endoscopic interventions that have been shown to be effective should not be held to a higher standard than bariatric surgery for coverage and durability needs to be understood in the context that there is often not a cure with one intervention. The current lack of endoscopic coverage leaves patients without effective interventions with unclear reasons.

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[2] https://www.esge.com/assets/downloads/pdfs/2024_a-2292-2494.pdf
[3] https://asmbs.org/resources/endorsed-procedures-and-devices/
[4] https://www.aasld.org/new-masld-nomenclature

**Edits to specific sections of policy bulletin 0157**

We included specific changes our societies recommend for policy bulletin 0157 during the upcoming review process in Attachment A. Below is a summary of our recommendations:

- Section I.A.1.a.ii.e footnote: We recommend defining advanced hepatic fibrosis as stage 2 or higher on Fibroscan or magnetic resonance elastography and moderate or higher on enhanced liver fibrosis test.
- Section I.A.2.a: It is unclear if this is 12 visits over the span of 12 months. We recommend shortening to 3 months as data demonstrates early weight loss predicts long-term/1 year weight loss and <5% total body weight loss (TBWL) at 3 months is considered non-response[5, 6].
- Section 2.A, bullet titled, "Natural orifice transoral endoscopic surgery (NOTES) techniques for bariatric surgery including, but may not be limited to, the following:" We recommend deleting bullets 1, 3, and 6 from the list of experimental, investigational, or unproven procedures (see below). We recommend Aetna cover ESG, TORe and IGB for the following reasons:
    - Delete "Endoscopic outlet reduction (transoral outlet reduction (TORe)) for treatment of weight gain after Roux-en-Y gastric bypass; or"
        - This section contains a recent systematic review and meta-analysis that shows that pursestring full thickness TORe is effective. 1 year data is what we use for obesity medication efficacy and TORe has 12-month outcomes as well. Longer data is also reported. Additionally, the procedure is intended to be iterative. The TORe section could benefit from this: https://pubmed.ncbi.nlm.nih.gov/40711436/.
        - TORe has proven to be effective and the ability to use it in combination with other therapies is how obesity needs to be treated rather than in silos. Additionally, TORe with even older/cheaper generation obesity medications has been shown to be better and safer than surgical revision: https://pubmed.ncbi.nlm.nih.gov/37150416/.
    - Delete "Intragastric balloon (e.g., the Obalon Balloon System, and the ReShape Integrated Dual Balloon System); or"

[5] https://pmc.ncbi.nlm.nih.gov/articles/PMC2713356/

[6] https://www.johs.com.sa/admin/public/uploads/187/381_pdf.pdf#:~:text=Clinically%20significant%20weight%20loss%20is%20generally%20defined,modifications%20into%20all%20obesity%20management%20strategies%20(7)

        - Intragastric balloon procedures are no longer investigational, as supported by moderate certainty evidence. The AGA technical review[7] and guideline[8] support the therapy and show sustained weight loss after balloon removal. Additionally, AGA suggests further therapies after removal, which is reasonable as obesity is chronic relapsing/remitting disease.
    - Delete "Transoral gastroplasty (TG) (vertical sutured gastroplasty; endoluminal vertical gastroplasty; endoscopic sleeve gastroplasty); or"
        - Aetna included the IFSO Bariatric Endoscopy Committee's evidence-based review and position statement on ESG[9] and the ASGE-ESGE guideline on primary endoscopic bariatric and metabolic therapies for adults with obesity[10] which indicate moderate quality of evidence based on randomized controlled trials and support coverage of ESG.
        - Additionally, Aetna quoted durability at 5 years, "Abu Dayyeh and colleagues showed its durability on the basis of weight loss outcomes."
        - Lastly, the ASMBS endorsed[11] ESG as a safe, effective, and evidence-based intervention for the treatment of metabolic and bariatric disease, reflecting the current clinical best practice.

- Background section, subsection titled, "Mini Sleeve Gastrectomy by Natural Orifice Trans-endoluminal Endoscopic Surgery (NOTES): Mini Sleeve Gastrectomy by Natural Orifice Trans-endoluminal Endoscopic Surgery (NOTES) and Overstitch sections." We recommend including additional literature in the summary.
    - Note that the data discussed for TORe focuses more on how the procedure was developed rather than how it is currently performed in its current effective form.
    - Regarding endoscopic revision of sleeve gastrectomy compared to surgical revision or conversation to roux-en-y gastric bypass, endoscopic avenues have also been shown to be more favorable for safety with similar efficacy. We recommend including the 2025 study, Endoscopic versus surgical management of recurrent weight gain following sleeve gastrectomy[12].

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[7] https://www.gastrojournal.org/article/S0016-5085(21)00434-0/fulltext
[8] https://www.gastrojournal.org/article/S0016-5085(21)00477-7/fulltext
[9] https://pubmed.ncbi.nlm.nih.gov/39482444/
[10] https://www.esge.com/assets/downloads/pdfs/2024_a-2292-2494.pdf
[11] https://asmbs.org/resources/endorsed-procedures-and-devices/
[12] https://pubmed.ncbi.nlm.nih.gov/41213337/

- Table: Applicable CPT / HCPCS / ICD-10 Codes:
    - We recommend adding new Category I CPT code 43889 to the section "CPT codes covered if selection criteria are met."
    - We recommend deleting HCPCS code C9785 from the section "HCPCS codes not covered for indications listed in the CPB" because CMS deleted this code effective January 1, 2026.

Thank you for the opportunity to provide feedback on the Aetna Obesity Surgery Clinical Policy Bulletin Number 0157. If you have any questions about our request or if we may provide any additional information, please contact Brad Conway, ACG, at 301-263-9000 or bconway@gi.org; Leslie Narramore, AGA, at 410-349-7455 or Lnarramore@gastro.org; and Eden Essex, ASGE, at 630-570-5646 or eessex@asge.org. We are happy to make our experts available for a virtual meeting if that would be helpful.

Sincerely,

American College of Gastroenterology
American Gastroenterological Association
American Society for Gastrointestinal Endoscopy