Reem Sharaiha, MD MSc

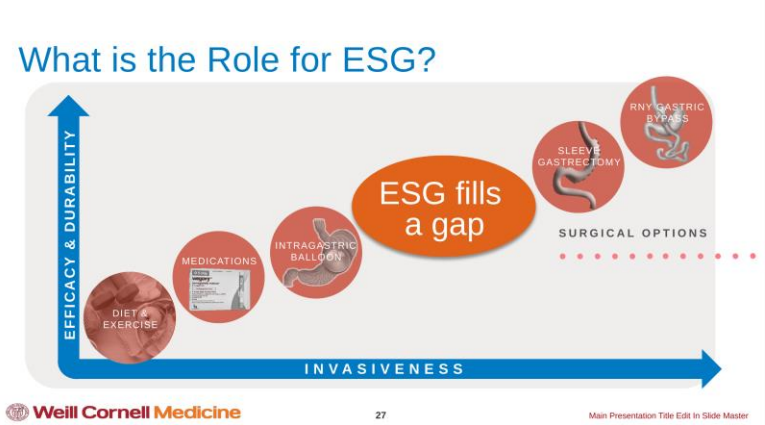
Professor of Medicine
Chief of Endoscopy
Director of Therapeutic and Advanced Endoscopy
Director of Bariatric & Metabolic Endoscopy
Weill Cornell Medicine

Pathways to Credentialing, Reimbursement, and Scaling Endoscopic MBS

XXIX IFSO World Congress · Toronto · 2 September 2026

What we do know

- Obesity prevalence has not fallen in the last 10 years, despite highly effective pharmacotherapy
- Metabolic and bariatric surgery remains the most effective long term treatment
- **It is critically underutilised – less than 1% of eligible patients undergo intervention**
  - That figure is not a US figure. It is the same story in every health system in this room
- Endoscopic therapies sit between medication and surgery, and reach patients who decline both



The evidence question is closed

- **ACG 2026 – four STRONG recommendations at moderate certainty: ESG in class 1+ obesity, ESG with T2DM or MASLD, TORe after RYGB, IGB with lifestyle**
- ASGE and ESGE 2024 – primary EBMTs at BMI ≥30, or ≥27 with comorbidity (GRADE)
- IFSO Bariatric Endoscopy Committee 2024 – ESG is a valid bariatric procedure
- ASMBS and IFSO 2022 – formally supersedes the 1991 NIH thresholds
- NICE HTG711 – ESG at BMI ≥30, or ≥27.5 in South Asian, Chinese, Middle Eastern, Black African and African-Caribbean patients
- MERIT, Lancet 2022 – 49% EWL vs 3%, serious adverse events 2%

Five bodies, three continents, one conclusion. We are not arguing about efficacy any more.

Abu Dayyeh et al, Lancet 2022 · Jirapinyo et al, Endoscopy 2024 · Abu Dayyeh et al, Obes Surg 2024 · Eisenberg et al, Obes Surg 2023 · NICE HTG711

Three things stand between evidence and access

- **Regulatory approval – national, and largely done**
- **Payment – national, and moving country by country**
- **Capacity – the people trained to do it**
  - The first two we negotiate at home. The third we can only solve together.

I will use my own system as the worked example on payment. The sequence is the same everywhere; only the timeline differs.

How we used to get paid

- **CPT 43999 — unlisted procedure, stomach**
- Priced by analogy to 43860, open revision of gastrojejunal anastomosis
  - A pre-authorisation letter written for every single patient
  - No published rate, so nothing a hospital could budget against
  - No RVU credit — the work was invisible in every productivity model
- **Result: cash pay or nothing. Selects for who can afford it, not who needs it**

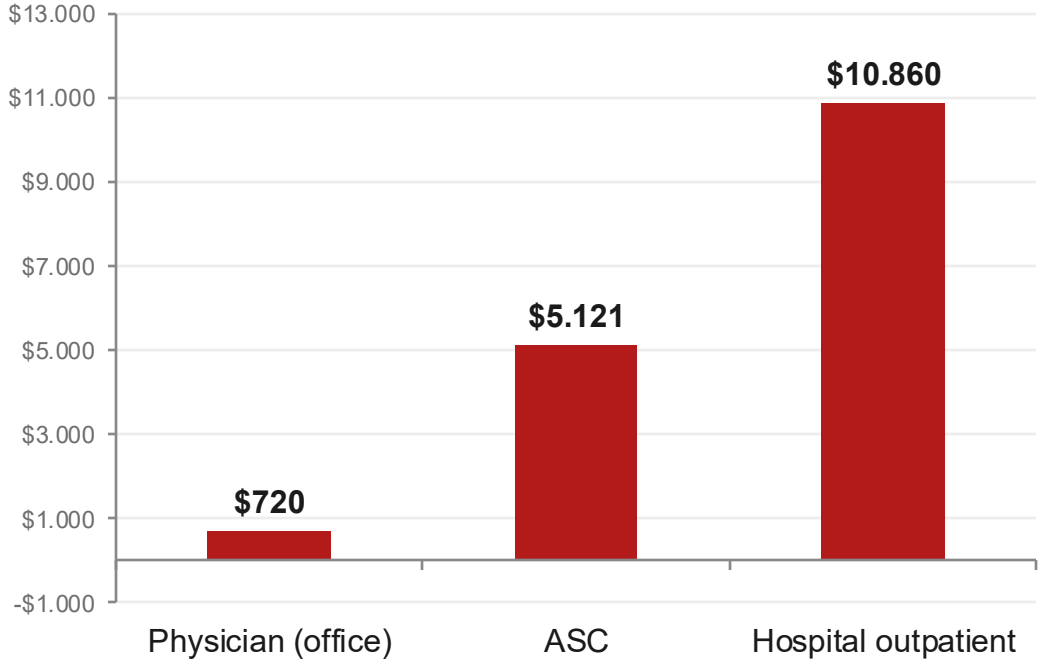
1 January 2026

CPT 43889

“Gastric restrictive procedure, transoral, endoscopic sleeve gastroplasty (ESG), including argon plasma coagulation, when performed”

- Category I. Not a T-code, not temporary
- 90 day global period
- Placed with the bariatric surgery codes, not in the endoscopy family

What it pays



- **Work RVU 12.56 · total RVU 21.55**
- **Site of service is now the biggest single lever on programme economics**
- Do not report with 43191, 43197, 43200 or 43235
- Balloons (43290 / 43291) remain non-covered by Medicare

What travels: a dedicated code is what turns a procedure into a programme. Site of service then becomes the biggest lever you have.

2026 national averages, before sequestration

The 90 day global cuts both ways

What it protects

- One payment covers the episode rather than a fragmented set of claims
- Removes the incentive to under-follow patients
- Unrelated GI care and non-endoscopic obesity management can still be billed separately

What it exposes

- Aftercare drives the outcome, and it now sits inside the payment
- Dietitian, behavioural and nursing time must be costed in, not bolted on
- A programme that skips aftercare will look cheap and perform badly

Any bundled payment does this, in any country. Budget the aftercare up front or your results will not match the trials.

One code, one procedure

ESG	CPT 43889. Category I, from January 2026
TORe	Still CPT 43999, unlisted. Exactly where ESG sat for a decade
Intragastric balloons	Codes exist, but Medicare does not cover them
Everything else	No dedicated code, no coverage pathway

- TORe carries a STRONG recommendation at moderate certainty in the same guideline. It has no code.
- Getting 43889 took registry data, a randomised trial and a coordinated society ask. That sequence is repeatable.

The procedures with the strongest metabolic case sit on the weakest payment pathways.

The payers have already moved

Cigna, policy 0051	Effective 15 Feb 2026. ESG medically necessary at BMI 35, or 30–34.9 with a comorbidity
Anthem CG-SURG-83	Revised Nov 2025. ESG added to the medically necessary list
NICE HTG711	BMI 30, or 27.5 in South Asian, Chinese, Middle Eastern, Black African and African-Caribbean patients
ASGE / ESGE 2024	BMI 30, or 27 with a comorbidity. GRADE based
ASMBS / IFSO 2022	Supersedes the 1991 NIH thresholds outright

If a plan is still applying 1991 criteria, two of the largest US commercial payers and the UK's own technology assessment body have already left them behind.

Cigna MCP 0051 · Anthem CG-SURG-83 · NICE HTG711 · Jirapinyo et al, Endoscopy 2024 · Eisenberg et al, Obes Surg 2023

The denials are the same in every system

They say	You say
BMI below our threshold	That threshold is the 1991 NIH statement. ASMBS and IFSO superseded it in 2022
Investigational	FDA De Novo 2022. A Category I code from 2026. Regulators do not do that for investigational procedures
No 6 month supervised diet	ASMBS 2016 recommends against it. No evidence, and it delays care
Behavioural clearance not met	Cleared, dated, documented. Tell me exactly which instrument you want
Should have had a sleeve	NICE names patients who decline surgery as a beneficiary group
GERD is a contraindication	NICE reviewed this in HTG711. It is not
Try a GLP-1 first	Trialled. No guideline requires exhausting pharmacotherapy first

Never: apologise, accept another three months of delay, or mention that the patient could self-pay.

What competence actually is

- **FITE-1: a global expert consensus, modified Delphi, three rounds**
  - Every panellist had performed more than 300 ESG procedures. Gastroenterologists and surgeons, academic and private practice
- **27 statements: 6 cognitive, 21 technical**
- **The six cognitive skills, at 100% consensus:**
  - Know the endoscopic bariatric options and where they sit among all obesity treatments
  - Know indications, contraindications and patient selection
  - Consent properly for the real risks
  - Manage the peri-procedural course – antiemetics, analgesia, antibiotics, diet
  - Diagnose and manage adverse events
  - Communicate with the team

Jirapinyo, Advani, Al-Sabban, McGowan, Sharaiha, Alqahtani, Larsen, Laster, Maselli, Singh, Thompson. Gastrointest Endosc 2025;102:285-9

The technical standard we agreed on

Highest consensus

- Start suture 1 at the incisura, first stitch on the anterior wall
- 6 to 12 full-thickness bites on suture 1, running or U-pattern
- 6 to 10 sutures in total
- Do not suture the fundus

Explicitly optional

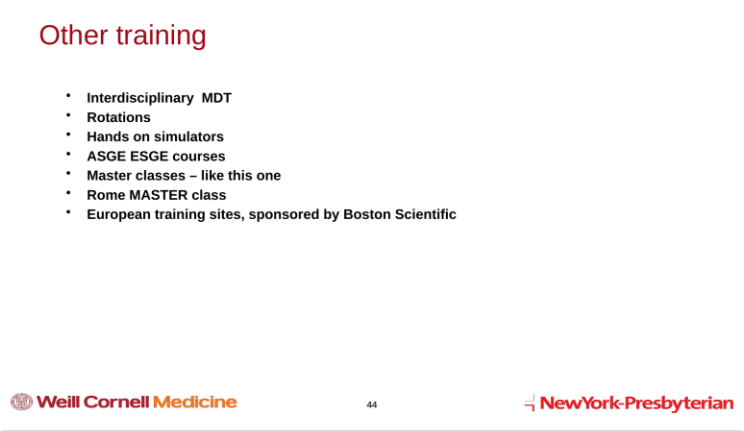
- Overtube
- Argon plasma coagulation marking of the gastric boundaries
- Interrupted reinforcement suture beside the first
- Scope torquing to avoid alpha loops – judged too advanced to mandate

MERIT used a pattern most experts now consider inadequate. Standardising the procedure is how we stop arguing about whose results are real.

FITE-1 consensus, Gastrointest Endosc 2025

How people are actually trained today

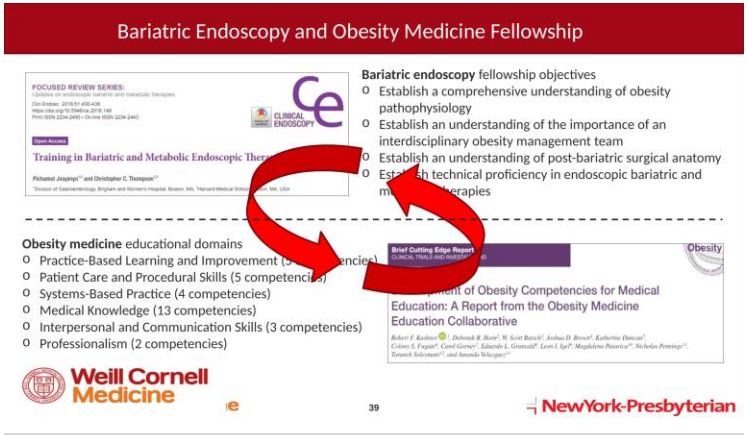
- **Accredited fellowship – still the only route with structured assessment**
- Society courses – ASGE, ABE, ESGE
- Master classes and congress hands-on sessions, including this one
- The Rome MASTER class
- European training sites, industry sponsored
- Hands-on simulators
- Interdisciplinary team rotations
- **Most programmes require a number of supervised procedures before independent practice. Nobody agrees on the number.**



Seven routes in, no common exit standard. That is the problem in one line.

A fellowship model you can copy

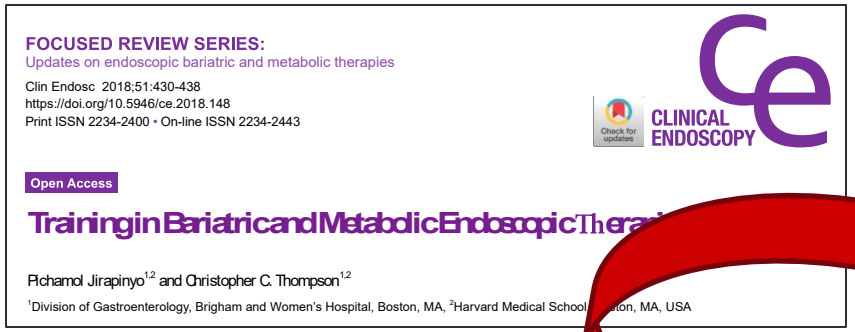
- **Bariatric Endoscopy and Obesity Medicine Fellowship, Weill Cornell**
  - Built jointly across Gastroenterology, Endocrinology and the Comprehensive Weight Control Center
- **Four objectives:**
  - Understand obesity pathophysiology
  - Understand why the interdisciplinary team matters
  - Understand post-bariatric surgical anatomy
  - Achieve technical proficiency in endoscopic bariatric and metabolic therapies
- **Mapped onto 32 obesity medicine competencies across six domains**



Note the order. Technical proficiency is the fourth objective, not the first.

Jirapinyo and Thompson, Clin Endosc 2018 · Kushner et al, Obesity Medicine Education Collaborative

Bariatric Endoscopy and Obesity Medicine Fellowship



FOCUSED REVIEW SERIES:
Updates on endoscopic bariatric and metabolic therapies

Clin Endosc 2018;51:430-438
https://doi.org/10.5946/ce.2018.148
Print ISSN 2234-2400 • On-line ISSN 2234-2443

CLINICAL ENDOSCOPY

Open Access

Training in Bariatric and Metabolic Endoscopic Therapies

Pichamol Jirapinyo[1,2] and Christopher C. Thompson[1,2]

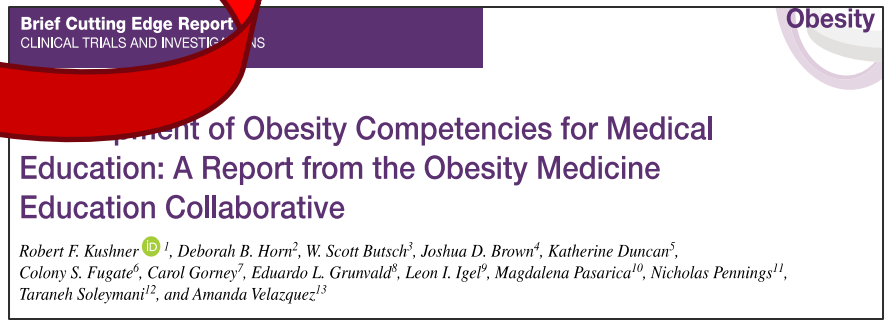
[1]Division of Gastroenterology, Brigham and Women's Hospital, Boston, MA, [2]Harvard Medical School, Boston, MA, USA

Bariatric endoscopy fellowship objectives

- Establish a comprehensive understanding of obesity pathophysiology
- Establish an understanding of the importance of an interdisciplinary obesity management team
- Establish an understanding of post-bariatric surgical anatomy
- Establish technical proficiency in endoscopic bariatric and metabolic therapies

Obesity medicine educational domains

- Practice-Based Learning and Improvement (3 competencies)
- Patient Care and Procedural Skills (5 competencies)
- Systems-Based Practice (4 competencies)
- Medical Knowledge (13 competencies)
- Interpersonal and Communication Skills (3 competencies)
- Professionalism (2 competencies)



Brief Cutting Edge Report
CLINICAL TRIALS AND INVESTIGATIONS

Obesity

Development of Obesity Competencies for Medical Education: A Report from the Obesity Medicine Education Collaborative

Robert F. Kushner[1], Deborah B. Horn[2], W. Scott Butsch[3], Joshua D. Brown[4], Katherine Duncan[5], Colony S. Fugate[6], Carol Gorney[7], Eduardo L. Grunvald[8], Leon I. Igel[9], Magdalena Pasarica[10], Nicholas Pennings[11], Taraneh Soleymani[12], and Amanda Velazquez[13]

Weill Cornell Medicine

NewYork-Presbyterian

Endobariatric Obesity Fellowship--

US Endobariatric Programs in academic medical centers, including:

- **WEILL CORNELL Medicine**
- Mayo
- Brigham & Women's
- Houston Methodist/UT
- University of Michigan
- **Robert Wood Johnson**
- **UCLA *(new program)***
- Cleveland Clinic ***(new program)***
- Cedars Sinai ***(new program)***

Weill Cornell Medicine

AMERICAN BOARD of OBESITY MEDICINE

APPLICATION DEADLINES AND FEES

2022 Application Deadline: July 15, 2022 ($1,500 fee)

Late Application Period: July 16-August 8, 2022 ($1,750 fee)

NewYork-Presbyterian

Obesity Multidisciplinary Case Teleconference

May 2022

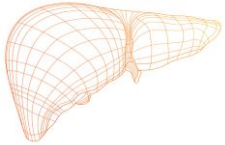
AMAZING THINGS ARE HAPPENING HERE

Weill Cornell Medicine

FibroScan® by echosens

Training Certificate

PARTICIPANT NAME	Okeefe Simmons
COURSE TITLE	Use Fibroscan 430
MODULES	Liver Stiffness & CAP
PROBES	Medium and XL Probe
COMPLETION DATE	Aug 27, 2021
REGISTRATION No.	UL20279082711
TRAINER	Anthony Aitken

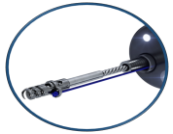


Training Manager

Debbie Wells

OverStitch™
Endoscopic Suturing System

X-Tack™
Endoscopic HeliX Tacking System



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Greg T. Prevatt
Greg T. Prevatt,
Director, Professional Education

Weill Cornell Medicine

Multidisciplinary Care for NAFLD/Obesity

Weill Cornell Medicine
Innovative Center for Health and Nutrition in Gastroenterology

- Integrated approach to the management of patients with NAFLD (and GI disease related to obesity) with other metabolic comorbidities
- Enhance communication among providers and to patients
- Improve clinical outcomes

On site
- GI/Hepatology
- Endocrinology
- APPs
- Research team
- Patient navigator

Telehealth
- Dietitians

Direct referral pathway
- Cardiology
- Bariatric surgery

Why Endura?

Obesity is a chronic, progressive disease for which there is no single solution.

endura
Weight Loss Solutions

Our approach to endobariatrics is changing the way obesity is treated.

Patients deserve solutions that account for the lifetime struggle of weight loss.

Patients want options and non-surgical alternatives to lasting weight loss.

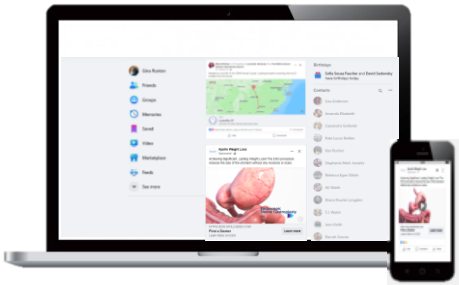
Patients need support from start to post-procedure.

NewYork-Presbyterian

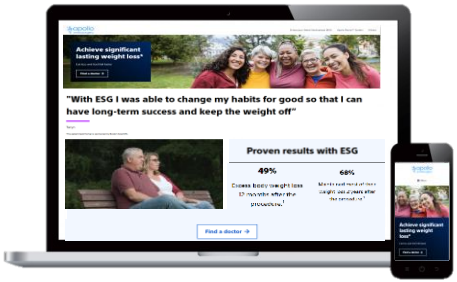
Consumer Awareness

endura
Weight Loss Solutions

REACH
Advertising



ENGAGE
Patient Website



CONNECT
Find a Doc

Consumer awareness is the #1 driver of commercial success and the #1 barrier our physician customers face.

The pathway, and what is still missing

What we have

- Accredited GI fellowship or surgical residency
- Competency in upper endoscopy and haemostasis
- Validated simulator training, structured didactics, proctored cases at experienced centres
- Institutional privileging with initial and ongoing assessment
- Board certification in obesity medicine (ABOM) for those who want it
- **Current guidance: accredited fellowship or equivalent, and a minimum of 100 supervised procedures**

What we do not have

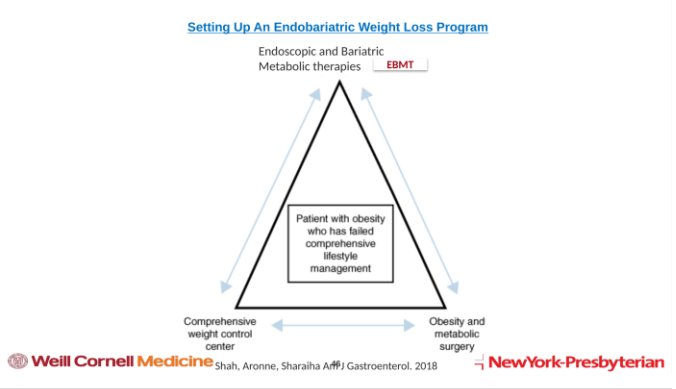
- No validated skill assessment tool
- No agreed learning curve
- No defined competence threshold
- No quality metrics or outcome benchmarks for EBTs
- No mandatory curriculum anywhere in the world
- Named as the next piece of work in both my own teaching and the FITE-1 consensus. It is not national. It belongs to a body like this one.

ACG Bariatric Endoscopy Guideline 2026 · ASGE privileging and proctoring framework · FITE-1, Gastrointest Endosc 2025

The bottleneck is people, not codes

"The limited number of trained proceduralists remains an important barrier to access"

- Operators – fellowship exposure and proctored pathways at scale, not one-off courses
- Team – dietitian, behavioural and nursing capacity sized to volume from day one
- Site of service – decided deliberately, not by default
- Outcomes – a registry from the first case, so the next guideline is built on all of our data



Shah, Aronne, Sharaiha, Am J Gastroenterol 2018

Take home

- **The evidence question is closed**
  - Guidelines on three continents agree. Argue about delivery, not efficacy.
- **Payment is being solved, country by country**
  - One procedure at a time. The arguments that win with a payer are the same everywhere, and the sequence that won ESG a code is repeatable.
- **Capacity is the constraint, and it is a training problem**
  - We now have a global standard for what competent ESG is. We have no way to assess it. That is the next piece of work, and it belongs to IFSO.

rzs9001@med.cornell.edu