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2023 Billing and Coding Guide

Bariatric surgery

Overview

This guide is intended to aid providers in appropriate procedure code selection for Bariatric surgery procedures. The document reflects applicable and commonly billed procedure codes as well as the unadjusted national Medicare average rates assigned to the CPT®[1] code.

Instructions for use:

- Full code descriptions and details of code reporting requirements and/or guidance, can be found in the section labeled coding.
- Physician, Hospital Outpatient, and/or Ambulatory Surgery Center (ASC) rates, can be found in the section labeled reimbursement.
- Details surrounding specialized coding and reimbursement information can be found in the corresponding appendices, FAQ sections, and indicated in footnotes.
- This document is not all-inclusive, nor does it replace advice from your coding and compliance departments and/or CPT®[1] coding manuals.

Coverage

Medicare

Traditional Medicare

For traditional Medicare patients, Medicare has issued a national coverage determination (NCD #100.1) for bariatric surgery.

Medicare Administrative Contractor (MAC) have issued many local coverage determinations for bariatric surgery.

Medicare Advantage

Medicare Advantage plans are required to cover at least what is covered by Traditional Medicare. Medicare coverage policies apply to both traditional Medicare and Medicare Advantage plans.[2]

Medicare Advantage plan administrators may have policies and additional requirements such as prior authorization.

Commercial payers

Non-Medicare, commercial payers typically determine coverage for procedures based on applicable medical policies. Prior authorization may be required. Not all published policies apply to all patients covered by a particular payer. There may be plan specific coverage limitations.

Medtronic recommends providers review specific payer coverage policies applicable to a patient to verify all the criteria for coverage are met, including possible prior authorization requirements.

Coverage

Best practices for documentation

The medical record must support the medical necessity of all procedures being performed.

Best practice considerations:

- Identify a staff member to coordinate all prior authorizations
- Leverage specific payer websites/portals to ensure latest coverage and submission requirements are followed
- Ensure submission of clinical information is accurate and reflects requirements within the medical policy
- Relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures may be required
- Consider including a clear and concise letter of medical necessity to summarize how the patient has met the payer's coverage criteria
- Submit information and maintain record of authorization review progress until a coverage decision is made

Common criteria for coverage

- BMI (typically, 40+ without comorbidities or 35-40 with comorbidities)
- Comorbidities like hypertension, diabetes, hyperlipidemia, coronary artery disease, obstructive sleep apnea, degenerative joint disease
- Clearance from a mental health provider
- Pre-operative compliance with medically managed weight loss program and failure to achieve weight loss
- Description of planned procedure
- Patient commitment to compliance with postoperative behavioral changes

Coding

The coding information below does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. All diagnosis and procedure codes must be supported by clear documentation within the medical record.

- HCPCS[3] II codes
- CPT®[1] procedure codes
- ICD-10-PCS[4] and ICD-10-CM[5] diagnosis codes
- Coding appendix

HCPCS[3] II codes

Level II HCPCS[3] codes are primarily used to report supplies, drugs and implants that are not reported by a CPT®[1] code. HCPCS codes are reported by the physician, hospital or DME provider that purchased the item, device, or supply. Different payers have different payment methods for these items.

C-codes are a series of HCPCS codes that facilities reimbursed under the Medicare Outpatient Prospective Payment System (OPPS) are required to report for eligible items and services. Medicare assigns C-codes to specific devices eligible for pass-through payment. Every year, in the OPPS rule, Medicare publishes a list of CPT®[1] and HCPCS codes that are designated as device-intensive procedures. When reporting procedures on this list, facilities should capture both the CPT®[1] code representing the procedure performed and the C-code representing the device used. Although C-codes only affect Medicare outpatient reimbursement, facilities may also want to report C-codes on inpatient claims if the device is not used exclusively for inpatient procedures. Medicare tracks this information and uses it in its rate-setting process. Non-OPPS facilities may report C-codes at their discretion.

HCPCS[3] II S-codes cannot be reported to Medicare. They are used only by non-Medicare payers, which cover and price them according to their own requirements.

HCPCS[3] code	Description
S2900	Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline
A4649	Surgical supply; miscellaneous

CPT®[1] procedure codes

CPT®[1] code	Description
Gastric bypass, laparoscopic	
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
Gastric band, laparoscopic	
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (ie, gastric band and subcutaneous port components)
Gastric band, revision and removal of band, laparoscopic	
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
Gastric band, revision and removal of port	
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only

CPT®[1] procedure codes

CPT®[1] code	Description
Sleeve gastrectomy	
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
Biliopancreatic diversion without duodenal switch	
43632	Gastrectomy, partial, distal; with gastrojejunostomy
Biliopancreatic diversion with duodenal switch	
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)
Gastric bypass, open	
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
Revision, gastric restrictive procedure	
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)

CPT®[1] procedure codes

CPT®[1] code	Description
Other revision	
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy
Single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S)	
43659	Unlisted laparoscopy procedure, stomach
43999	Unlisted procedure, stomach
44799	Unlisted procedure, small intestine
44238	Unlisted laparoscopy procedure, intestine (except rectum)

ICD-10-PCS[4] codes

ICD-10-PCS procedure codes are used by hospitals to report surgeries and procedures performed in the inpatient setting. Below are commonly used ICD-10-PCS procedure codes, however codes listed below are not exhaustive as other codes may apply.

ICD-10-PCS[4] code	Description
Sleeve gastrectomy, laparoscopic	
0DB64Z3	Excision of Stomach, Percutaneous Endoscopic Approach, Vertical
Roux-en-y gastric bypass, open	
0D160ZA	Bypass Stomach to Jejunum, Open Approach
0D1A0ZA	Bypass Jejunum to Jejunum, Open Approach
Biliopancreatic diversion With duodenal switch (BPD-DS), open	
0DB60Z3	Excision of Stomach, Open Approach, Vertical
0D190ZB	Bypass Duodenum to Ileum, Open Approach
0D1B0ZB	Bypass Ileum to Ileum, Open Approach
Single anastomosis duoden-ileal bypass with sleeve gastroectomy (SADI-S) laparoscopic	
0DB60Z3	Excision of Stomach, Open Approach, Vertical
0D194ZB	Bypass Duodenum to Ileum, Percutaneous Endoscopic Approach
Adjustable gastric band, laparoscopic	
0DV64CZ	Restriction of Stomach With Extraluminal Device, Percutaneous Endoscopic Approach
0DW64CZ	Revision of Extraluminal Device In Stomach, Percutaneous Endoscopic Approach
0DP64CZ	Removal of Extraluminal Device From Stomach, Percutaneous Endoscopic Approach
Robotic assistance	
8E0W0CZ	Robotic Assisted Procedure of Trunk Region, Open Approach
8E0W4CZ	Robotic Assisted Procedure of Trunk Region, Percutaneous Endoscopic Approach

Coding for Bariatric Surgery

ICD-10-CM[5] diagnosis codes are used by providers and facilities to indicate the reason for the encounter.

Bariatric procedures are performed for patients that have a diagnosis of obesity. While patients typically have associated comorbidities that should also be coded and reported, obesity remains the primary reason for the procedure. Payers may also require that a specific BMI be reported to meet coverage criteria. ICD-10-CM also provides codes specifically for complications of bariatric procedures.

The codes displayed are representative of diagnoses and procedures that are associated with bariatric surgery. Other diagnosis and procedure codes may also be available. Providers should check with their coding advisors and payers for additional or alternate codes.

ICD-10-CM[5] diagnosis code	Description
Obesity	
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.8	Other obesity
BMI	
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) 50-59.9, adult
Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.45	Body mass index (BMI) 70 or greater, adult
Complications	
K95.01	Infection due to gastric band procedure
K95.09	Other complications of gastric band procedure
K95.81	Infection due to other bariatric procedure
K95.89	Other complications of other bariatric procedure

Coding appendix

NCCI edits

The Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding, with the overall goal of reducing improper payments of Medicare Part B and Medicaid claims. Providers should consider NCCI edits when submitting claims.[6]

Unlisted codes

Unlisted codes do not have established RVUs under Medicare's Physician Payment System and are typically priced by the contractor after review and individual consideration.

Unlisted CPT®[1] codes do not carry a rate assignment from Medicare in the physician office setting. Payment may be available on a case-by-case basis with submission of medical records.

Reimbursement

This section provides 2023 Medicare unadjusted national average allowable rates for physician, hospital outpatient, and ambulatory surgery settings. CPT®[1] code descriptions in this section have been shortened to the consumer-friendly version per AMA guidelines.[7]

Providers may choose to perform multiple procedures during the same encounter. When this occurs, providers must report all procedures and the payment may be subject to packaging rules, multiple procedure reduction, complexity adjustments, or multiple endoscopy reductions.

- Physician[8], Hospital Outpatient[9], and Ambulatory Surgery[9] national unadjusted reimbursement rates
- Inpatient[10] national unadjusted reimbursement rates
- Reimbursement appendix

Reimbursement

Physician, Hospital Outpatient, and Ambulatory Surgery national unadjusted reimbursement rates

		Physician[8]			Hospital Outpatient[9]			Ambulatory Surgery[9]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Gastric bypass, laparoscopic									
43644	Bypass of stomach using an endoscope	29.40	NA	$1,756	NA	C	NA	NA	NA
43645	Bypass of stomach with reconstruction of small bowel using an endoscope	31.53	NA	$1,866	NA	C	NA	NA	NA
Gastric band, laparoscopic									
43770	Insertion of adjustable stomach reduction device using endoscope	18.00	NA	$1,142	5362	J1	$9,087†, ¶	NA	NA
Gastric band, revision and removal of band, laparoscopic									
43771	Adjustment of stomach reduction device using an endoscope	20.79	NA	$1,296	NA	C	NA	NA	NA
43772	Removal of stomach reduction device using an endoscope	15.70	NA	$961	5303	J1	$3,261†	NA	NA
43773	Replacement of stomach reduction device using an endoscope	20.79	NA	$1,296	5361	J1	$5,212†	NA	NA
43774	Removal of stomach reduction device and port using an endoscope	15.76	NA	$974	5303	J1	$3,261†	G2	$1,501

Please refer to page 18 for footnotes

Reimbursement

Physician, Hospital Outpatient, and Ambulatory Surgery national unadjusted reimbursement rates

		Physician[8]			Hospital Outpatient[9]			Ambulatory Surgery[9]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Gastric band, revision and removal of port									
43887	Removal of port for saline injection into stomach banding device	4.32	NA	$339	5054	Q2	$1,726[§]	G2	$899
43888	Replacement of port for saline injection into stomach banding device	6.44	NA	$474	5055	T	$3,253	G2	$1,694
Sleeve gastrectomy, laparoscopic									
43775	Partial removal of stomach for weight loss using endoscope	20.38	NA	$1,118	NA	C	NA	NA	NA
43842	Banding of upper stomach to reduce size of stomach	21.03	NA	$1,162	NA	E1	NA	NA	NA
Biliopancreatic diversion without duodenal switch									
43632	Removal of lower part of stomach with reattachment of remaining stomach to second part of small bowel	35.14	NA	$2,055	NA	C	NA	NA	NA
Biliopancreative diversion with duodenal switch									
43845	Partial removal of stomach, upper bowel, and ileum for weight loss	33.30	NA	$1,980	NA	C	NA	NA	NA

Please refer to page 18 for footnotes

Reimbursement

Physician, Hospital Outpatient, and Ambulatory Surgery national unadjusted reimbursement rates

		Physician[8]			Hospital Outpatient[9]			Ambulatory Surgery[9]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Gastric bypass, open									
43846	Bypass of stomach for weight loss with Roux-en-Y connection of upper bowel to upper stomach	27.41	NA	$1,672	NA	C	NA	NA	NA
Revision, gastric restrictive procedure									
43848	Revision of upper stomach bypass	32.75	NA	$1,954	NA	C	NA	NA	NA
Other revision									
43860	Revision of surgically created connection of stomach to small bowel	27.89	NA	$1,654	NA	C	NA	NA	NA
Single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S)									
43659	Other procedure on stomach using endoscope		Carrier priced		NA	C	NA	NA	NA
43999	Other procedure on stomach		Carrier priced		NA	C	NA	NA	NA
44799	Other procedure on small bowel		Carrier priced		NA	C	NA	NA	NA
44238	Other procedure on bowel using an endoscope		Carrier priced		NA	C	NA	NA	NA

Please refer to page 18 for footnotes

Reimbursement

Hospital inpatient DRG's for bariatric surgery

Under Medicare's MS-DRG[10] methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 750 diagnosis-related groups, based on the ICD-10 codes assigned to the diagnoses and procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Surgical supplies for bariatric procedures are typically included in the flat payment and are not paid separately. Only one MS-DRG[10] is assigned for each inpatient stay, regardless of the number of procedures performed. MS-DRGs shown are those typically assigned to the following scenarios when the patient is admitted specifically for the procedure.

Below are commonly used DRGs, however codes listed below are not exhaustive as other codes may apply.

MS-DRG[10]	Description	Rate
Primary bariatric procedures		
619	OR Procedures for Obesity W MCC	$19,836
620	OR Procedures for Obesity W CC	$11,562
621	OR Procedures for Obesity W/O CC/MCC	$10,667
Revision bariatric procedures		
326	Stomach, Esophageal and Duodenal Procedures W MCC	$35,112
327	Stomach, Esophageal and Duodenal Procedures W CC	$17,569
328	Stomach, Esophageal and Duodenal Procedures W/O CC/MCC	$11,371

MCC: Major Complications and/or Comorbidities **CC: Complications and/or Comorbidities**

Footnotes

NA	Indicates that there is no established Medicare allowable in this site of care
+	Add-on codes are always listed in addition to the primary procedure code
†	Comprehensive APCs (C-APCs)
††	Multiple Endoscopy Rule
¶	Device intensive
§	Packaged Payment, see Status Indicators in Reimbursement Appendix
||	Modifier, see definitions in Reimbursement Appendix
RVU	Indicates Relative Value Unit

Reimbursement appendix

Carrier priced

Carrier priced codes are not assigned a rate on a national level. Local contractors will determine the reimbursement amount on a case-by-case basis.

Inpatient Only (IPO) list

CMS can define procedures and services for which payment under the outpatient prospective payment system (OPPS) is inappropriate. Services designated as “inpatient only” are not appropriate to be furnished in a hospital outpatient department. Generally, inpatient only procedures are surgical services that require inpatient care because of the nature of the procedure.

Payment Indicator

In the ASC, the Payment Indicator shows how a code is handled for payment purposes. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost; A2 = surgical procedure, payment based on hospital outpatient rate adjusted for ASC; G2 = surgical procedure, non office-based, payment based on hospital outpatient rate adjusted for ASC.

Reimbursement appendix

Status Indicator

In the Hospital Outpatient, Status Indicator (SI) shows how a code is handled for payment purposes: C= Inpatient procedures, not paid under OPPS; J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; S = procedure or service not discounted when multiple procedure; Additional details can be found in Addendum D1 of the OPPS rule.

Work Relative Value Unit (RVU)

The Work RVU is a unit of measure that describes the work associated with a physician's procedural services and is factored into the total physician payment. Work RVU is one of three total components on which physician payment is based: physician work RVU, practice expense RVU, and medical malpractice RVU.[8]

Reimbursement appendix

w/MCC, w/CC or w/o CC/MCC

In the inpatient setting, w/MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs w/MCC have at least one major secondary complication or comorbidity. Similarly, w/CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs w/CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs w/o CC/MCC have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions were acquired in the hospital during the stay.

Frequently asked questions

01

How do I code a procedure that was robotically assisted?

When coding for robotic-assisted procedures in the outpatient setting or the professional fee, the CPT®[1] code that accurately describes the surgical procedure via laparoscopic approach should be used. There are no designated CPT®[1] codes or modifiers to report the use of robotic assistance. Some commercial payers may allow the use of HCPCS code S2900 to report robotic assistance. S codes should not be used when billing services to Medicare. When coding inpatient facility services, robotic assistance indexes to ICD-10-PCS code table 8E0.[10]

02

How do I appropriately code for the removal and replacement of both gastric band and subcutaneous port?

For removal and replacement of both gastric band and subcutaneous port, assign CPT®[1] code 43659, unlisted laparoscopy procedure, stomach. For physicians, CPT®[1] code 43659 is contractor priced. For hospital outpatient, CPT®[1] code 43659 maps to APC 5361, Level 1 Laparoscopy. Procedures which use unlisted codes such as 43659 are not permitted by Medicare in ASCs.[11]

Frequently asked questions

03

How do I appropriately code for the removal and replacement of both gastric band and subcutaneous port?

CPT®[1] code 43848 is used for open revision or reversal of gastric restrictive procedures, e.g. converting banding to gastric bypass, restapling a dehiscence of a staple restrictive line.[12]

04

What CPT®[1] code is used to report the physician work associated with SADI-S?

Physicians will report the appropriate unlisted CPT®[1] procedure code for their professional service associated with the surgery. Providers are encouraged to review the relevant medical policy on bariatric surgery. Some commercial payers have included guidance related to the use of either 43999[13] or 43659[14].

Frequently asked questions

05

What is the RVU assignment for an unlisted procedure code?

Relative value units (RVUs) are not assigned to unlisted codes because the codes do not identify usual procedural components, or the effort/skill required for the service. When using an unlisted code, it is necessary to provide specific information regarding the procedure(s) identified by the code (i.e., operative note, history and physical). The supporting documentation should include an adequate definition or description of the nature, extent and need for the procedure or service, as well as the time, effort, and equipment necessary to provide the service.[15, 16]

06

Is a modifier 26 (Professional Services) necessary for reporting the inpatient procedure?

No, it is not appropriate to append any modifier to an unlisted code because modifiers are used to indicate that a service or procedure has been altered by some specific circumstance, but not changed in its definition or code. Unlisted codes do not describe a specific service; therefore, it is not necessary to utilize modifiers.[17]

Frequently asked questions

07

Is SADI-S covered by insurance?

Providers are encouraged to verify coverage and benefits prior to providing care. Some payers may address coverage for SADI-S within their policies for Bariatric Surgery. For assistance with understanding the coverage in your area please contact the Medtronic Medical Surgical Reimbursement Support Program at Rs.MedtronicMedicalSurgicalReimbursement@Medtronic.com.

08

If the payer requires the use of another code can this be reported rather than the unlisted CPT®[1]?

Some payers have chosen to address SADI-S within their bariatric procedure policies and direct the use of alternate CPT®[1] codes, and in some cases existing codes that describe other procedures. Providers are encouraged to review member coverage and only use alternate coding when expressly required by the payer. When no such guidance exists the use of the unlisted CPT®[1] is recommended.

Frequently asked questions

09

Can unlisted procedure CPT®[1] codes be pre-authorized?

Pre-authorization options vary by payer. Traditional Medicare does not allow for pre-authorization for bariatric procedures. If reporting the unlisted procedure code to Traditional Medicare, coverage will be determined based on medical necessity. As discussed previously providers should be prepared to submit documentation of the work provided associated with the surgery. Commercial payers have various processes for authorization of unlisted codes. Providers are encouraged to check with the individual insurance carrier to determine the requirement for each patient.

Resources

Medtronic Reimbursement Support is available to assist you with your coding and reimbursement questions. If your coding or reimbursement questions were not answered in this guide, please check out these additional resources:

Visit our website: https://www.medtronic.com/covidien/en-us/support/reimbursement.html

Email us: rs.MedtronicMedicalSurgicalReimbursement@medtronic.com

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