Engineering the extraordinary

2024 Billing and Coding Guide

Bariatric surgery

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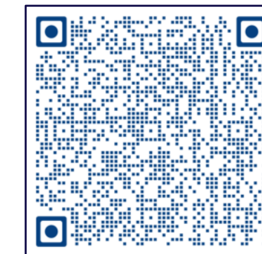
This guide is intended to aid providers in appropriate procedure code selection for Bariatric surgery procedures. The document reflects applicable and commonly billed procedure codes as well as the unadjusted national Medicare average rates assigned to the CPT®[1] code.

Instructions for use:

- New tools and updates can be found in the New for 2024 section.
- Code descriptions and details of code reporting requirements and/or guidance, as well as Physician, Hospital Outpatient, and/or Ambulatory Surgery Center (ASC) rates, can be found in the Coding & Reimbursement section.
- Details surrounding specialized coding and reimbursement information can be found in the FAQ and resources section.
- This document is not all-inclusive, nor does it replace advice from your coding and compliance departments and/or CPT®[1] coding manuals.



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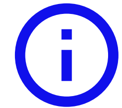

New Tool

Medtronic C-Code Finder

Launching January 2024, we will have a new tool specifically designed to access applicable commonly used C-codes as it relates to Medtronic products. Medicare provides C-codes, a type of HCPCS[3] II code, for hospital use in billing Medicare for some medical devices and supplies in the hospital outpatient setting. The C-code finder can be accessed at www.medtronic.com/c-code or by using the C-code button.

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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. Please contact Medtronic Reimbursement Support for questions related to coverage.

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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

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Coding & reimbursement

This section provides Medicare unadjusted national average allowable rates for physician, hospital outpatient, ambulatory surgery, and hospital inpatient settings. The coding information in this section 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.

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.

- HCPCS[3] II codes
- CPT®1 procedure codes and Physician[4] Hospital outpatient[5] and Ambulatory surgery center[5] reimbursement rates
- Inpatient[7] national unadjusted reimbursement rates and ICD-10 PCS[8] codes

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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 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

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Coding & reimbursement

Laparoscopic Bariatric Procedures

		Physician[4]				Hospital Outpatient[5]			Ambulatory Surgery[5]	
CPT®[1] code	Description	Global days	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Gastric bypass, laparoscopic										
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	090	29.40	NA	$1,706	Inpatient only				
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	090	31.53	NA	$1,812	Inpatient only				
Gastric band, laparoscopic										
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (ie, gastric band and subcutaneous port components)	090	18.00	NA	$1,109	5362	J1	$9,808[†¶]	NA	NA
Gastric band, revision and removal of band, laparoscopic										
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	090	20.79	NA	$1,258	Inpatient only				
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	090	15.70	NA	$936	5303	J1	$3,649[†]	NA	NA
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	090	20.79	NA	$1,258	5361	J1	$5,498[†]	NA	NA
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	090	15.76	NA	$946	5303	J1	$3,649[†]	G2	$1,799

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Open Bariatric Procedures

		Physician[4]				Hospital Outpatient[5]			Ambulatory Surgery[5]	
CPT®[1] code	Description	Global days	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Biliopancreatic diversion with duodenal switch										
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoilesostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	090	33.30	NA	$1,923	Inpatient only				
Gastric bypass, open										
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	090	27.41	NA	$1,624	Inpatient only				
Revision, gastric restrictive procedure, open										
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	090	32.75	NA	$1,901	Inpatient only				
Gastrojejunostomy revision, open										
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy	090	27.89	NA	$1,605	Inpatient only				
Gastric band, revision and removal of port										
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	090	4.32	NA	$331	5054	Q2	$1,738[§]	G2	$946
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	090	6.44	NA	$462	5055	T	$3,418	G2	$1,861

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Laparoscopic and Open Bariatric Procedures

		Physician[4]				Hospital Outpatient[5]			Ambulatory Surgery[5]	
CPT®[1] code	Description	Global days	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Biliopancreatic diversion without duodenal switch										
43632	Gastrectomy, partial, distal; with gastrojejunostomy	090	35.14	NA	$1,994	Inpatient only				
Single anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S)										
43659	Unlisted laparoscopy procedure, stomach	YYY	Carrier priced			5361	J1	$5,498	NA	NA
43999	Unlisted procedure, stomach	YYY	Carrier priced			5301	T	$864	NA	NA
44799	Unlisted procedure, small intestine	YYY	Carrier priced			5301	T	$864	NA	NA
44238	Unlisted laparoscopy procedure, intestine (except rectum)	YYY	Carrier priced			5361	J1	$5,498	NA	NA
Sleeve gastrectomy										
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	090	20.38	NA	$1,082	Inpatient only				
43842*	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	090	21.03	NA	$1,130	NA	E1	NA	NA	NA

*This service is not covered by Medicare. Rates provided are for reference only.

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Coding & reimbursement

ICD-10-CM[6] 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[6] 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
Other Postprocedural States	
Z98.84	Bariatric surgery status (gastric banding status, gastric bypass status for obesity, obesity surgery status)
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

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Inpatient[7] national unadjusted reimbursement rates

Under Medicare's MS-DRG[7] 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. The flat payment typically includes surgical supplies for bariatric procedures and are not paid separately. Only one MS-DRG 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 MS-DRGs, however, codes listed below are not exhaustive as other codes may apply.

MS-DRG[7]	Description	Rate
Primary bariatric procedures		
619	OR Procedures for Obesity W MCC	$18,222
620	OR Procedures for Obesity W CC	$11,358
621	OR Procedures for Obesity W/O CC/MCC	$10,624
Revision bariatric procedures		
326	Stomach, Esophageal and Duodenal Procedures W MCC	$35,561
327	Stomach, Esophageal and Duodenal Procedures W CC	$17,486
328	Stomach, Esophageal and Duodenal Procedures W/O CC/MCC	$11,184

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

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ICD-10-PCS[8] codes are used by hospitals to report surgeries and procedures performed in the inpatient setting. Below are commonly assigned ICD-10-PCS codes. However, the codes listed below are not exhaustive, as other codes may apply.

ICD-10-PCS[8] code	Description
Sleeve gastrectomy, laparoscopic with robotic assistance	
0DB64Z3	Excision of Stomach, Percutaneous Endoscopic Approach, Vertical
8E0W4CZ	Robotic Assisted Procedure of Trunk Region, Percutaneous Endoscopic Approach
Roux-en-Y gastric bypass (gastrojejunostomy), open	
0D160ZA	Bypass Stomach to Jejunum, Open Approach
Biliopancreatic diversion with duodenal switch (BPD-DS), open	
0D190ZB	Bypass Duodenum to Ileum, Open Approach
Single anastomosis duoden-ileal bypass with sleeve gastrectomy (SADI-S), laparoscopic	
0DB64Z3	Excision of Stomach, Percutaneous Endoscopic Approach, Vertical
0D194ZB	Bypass Duodenum to Ileum, Percutaneous Endoscopic Approach
Adjustable gastric band, laparoscopic	
0DV64CZ	Restriction of Stomach with Extraluminal Device, Percutaneous Endoscopic Approach
Revision or removal, gastric restrictive device, laparoscopic	
0DW64CZ	Revision of Extraluminal Device in Stomach, Percutaneous Endoscopic Approach
0DP64CZ	Removal of Extraluminal Device from Stomach, Percutaneous Endoscopic Approach

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Frequently asked questions

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.[7]

How do I appropriately code for the open revision or reversal of gastric restrictive procedures?

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.[9]

How do I appropriately code for the laparoscopic 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.[10]

What code(s) are reported when a laparoscopic biliopancreatic diversion with a duodenal switch is performed in the hospital outpatient department?

For facility reporting, assign only CPT®[1] code 43659, Unlisted laparoscopy procedure, stomach, for the laparoscopic biliopancreatic diversion with duodenal switch procedure. Assigning only CPT®[1] code 43659 is appropriate as it clinically corresponds to the open procedure code 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), both of which are located within the Stomach subsection of the Digestive System chapter of the CPT codebook.[11]

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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.

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 43659[12,13].

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.

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.[14, 15]

Is a modifier 26 (Professional Services) necessary for reporting an unlisted procedure code?

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.[16]

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.

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Appendix

Term	Footnote	Definition
Add-on CPT®[1] codes	+	An Add-on Code (AOC) is a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code that describes a service that is performed in conjunction with the primary service by the same practitioner. An AOC is rarely eligible for payment if it's the only procedure reported by a practitioner.
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.
Complexity adjustment		The complexity adjustments were implemented by CMS to provide for a payment adjustment when two or more high-cost procedures are performed and paid under Medicare's Hospital Outpatient Comprehensive APC system. To qualify, claims with certain code combinations must meet specific thresholds for both cost and frequency. When these thresholds are met, the code combinations qualify for reassignment to the next highest paying APC.
Comprehensive APC	†	Under its comprehensive APC (C-APC) policy, CMS makes payment for certain costly primary services and all other items and services reported on the hospital outpatient department claim, which CMS considers integral, ancillary, supportive, dependent, and adjunctive to the primary service and representing components of a complete comprehensive service.
Device intensive [17]	¶	Definition/symbol - The "device intensive" status is assigned to all surgical procedures with an individual HCPCS code-level device offset of greater than 40%. Device intensive procedures are identified in Addendum AA with a payment indicator of XX.
Inpatient only (IPO) list		CMS can define procedures and services for which payment under the outpatient prospective payment system (OPPS) is inappropriate. These codes have a status indicator of "C" (Addendum D1). 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
Modifiers[18]	‖	Modifiers are used to supplement the information or adjust the care description to provide extra details concerning a procedure or service. Modifiers help further describe a procedure code without changing its definition. Modifiers are appended to CPT®[1] codes. List of modifiers can be found in the CPT®[1] book.
Multiple endoscopy rule[19]	††	The multiple endoscopy rule requires that you always bundle diagnostic endoscopy with any surgical endoscopy within the same family. The multiple endoscopy rule applies only when the physician performs two or more endoscopies in the same family.
Packaged payment	§	Under OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.
Payment indicator		CMS uses payment indicators to identify each covered service that is eligible for ASC payment and the payment methodology by which the payment amount is calculated. The payment indicators also indicate which services' costs are packaged into the payment for other services and which surgical procedures are excluded from Medicare payment (72 FR 67189-67190)
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
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.
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.[7]
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.

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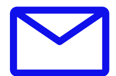
Resources

C-code Finder

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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Overview

New for 2024

Coverage

Coding & Reimbursement

FAQ & Resources