

## FAQ - Bariatric Surgery Coding from the ASMBS Insurance Committee

**CPT® and ICD-9 are dictated by payer policy guidelines.  
These codes are for reference only.**

**Disclaimer:** The coding, billing and reimbursement of any medical treatment or procedure is highly subjective, and is dependent upon the interpretation of multiple variables, to include differing Medicare fiscal agent Local Coverage Determinations, and a wide variety of commercial insurance payers' policies. American Society for Metabolic and Bariatric Surgery (ASMBS) presents the information in this guide only as general information and a point of reference. ASMBS does not and cannot guarantee or warranty that the reliance upon any information presented in this guide will result in any provider's compliance with a particular payer's coding, billing or reimbursement requirements. This guide does not and cannot constitute professional advice or be a substitute for applicable professional advice regarding the coding, billing or reimbursement for any specific circumstance. ASMBS highly recommends that every provider consult a coding, billing or reimbursement professional regarding the submission of any specific claim for reimbursement.

### Topics:

1. Gastric Band Adjustments: Billing, Coding, Medicare, etc.
2. Hiatal Hernia repair during band placement
3. Sleeve Gastrectomy
4. BPD/DS
5. Revisional Procedures and other scenarios
6. Insurance authorization, appeals, etc.

### 1. Gastric Band Adjustments: Billing, Coding, Medicare, etc.

#### Adjustments during the 90-day Global Period:

**QUESTION:** Once a patient has had laparoscopic gastric banding surgery and they are still in their 90-day global period, can the adjustments they receive during that 90-day global be billed?

**ANSWER:** No, gastric band adjustments cannot be billed within the 90-day global period.

According to the CPT manual (for CPT code 43770) the following guideline is stated: Typical postoperative follow-up care (see Surgery Guidelines, CPT Surgical Package Definition) after gastric restriction using the adjustable gastric restrictive device includes subsequent restrictive device adjustment(s) through the postoperative period for the typical patient. Adjustment consists of changing the gastric restrictive device component diameter by injection or aspiration of fluid through the subcutaneous port component.

Additional information can be found through CPT Assistant. Please see Volume 16, Issue 4, April 2006 at the following link:

[https://catalog.ama-assn.org/Catalog/cpt/searchresult\\_byIssue.jsp;jsessionid=22GHSLA05NYKHLA0MRPVX5Q?range=monthly&year=2006&month=Apr](https://catalog.ama-assn.org/Catalog/cpt/searchresult_byIssue.jsp;jsessionid=22GHSLA05NYKHLA0MRPVX5Q?range=monthly&year=2006&month=Apr)

**Adjustment Coding for Medicare Patients:**

There is no specific CPT code for an adjustment of the gastric band. Gastric band adjustments cannot be billed within the 90-day global period. According to the CPT manual (for CPT code 43770) the following guideline is stated: Typical postoperative follow-up care (see Surgery Guidelines, CPT Surgical Package Definition) after gastric restriction using the adjustable gastric restrictive device includes subsequent restrictive device adjustment(s) through the postoperative period for the typical patient. Adjustment consists of changing the gastric restrictive device component diameter by injection or aspiration of fluid through the subcutaneous port component.

Medicare (CMS) does not have a National Coverage Determination (NCD) for adjustments to the gastric band. It is recommended that you contact your Local Medicare Administrative Contractor (MAC) and inquire if there is a Local Coverage Determination (LCD) for gastric band adjustments. If a policy does not exist, inquire as to what CPT code your MAC would recommend.

If the local MAC does not have a policy or a coding recommendation, it is recommended that you have your Medicare patients sign an Advance Beneficiary Notice (ABN form CMS-R-131) for non-covered services.

An E/M service may also be submitted (using modifier 25) if it is separately identifiable from the actual adjustment. However, since there is some pre and post service work in doing the adjustment (interval history, etc.), the documentation must support that the patient's condition required "a significant, separately identifiable E/M service above and beyond" the other service provided. The documentation should indicate that the additional service was clearly different from the adjustment service that was performed and meet the documentation requirements of the level of E/M billed. Another component of the visit could include the time needed for outcomes reporting through BOLD or the ACS program. Some local Medicare contractors have agreed that if you can document the time for data entry as part of the visit, you could code for it as a level III or IV.

The temporary code (S2083 ADJUSTMENT OF GASTRIC BAND DIAMETER VIA SUBCUTANEOUS PORT BY INJECTION OR ASPIRATION OF SALINE) is not recognized by Medicare, and Medicare contractors cannot create local codes.

**E/M visit with Band Adjustment:**

**QUESTION:** Can an office visit (Evaluation and Management service E/M) be billed with a gastric band adjustment?

**ANSWER:** An E/M service may be billed (using modifier 25) if it is separately identifiable from the actual adjustment. For example, an appropriate evaluation of the patient's new compliant(s) or management issues, interval history, physical examination, medical decision-making, etc. is payable along with the adjustment procedure itself. If the patient had such a visit and decision-making previously, and is simply returning for the adjustment procedure, a separate E/M service should not be billed.

**Medicare Billing for Band Adjustment:**

**QUESTION:** How do I get paid for an adjustment in a Medicare Patient?

**ANSWER:** CMS does not have a National Coverage Determination (NCD) for adjustments to the gastric band. It is recommended that you contact your Local Medicare Administrative Contractor (MAC) and inquire if there is a

Local Coverage Determination (LCD) for gastric band Adjustments. If a policy does not exist, inquire as to what CPT code your MAC would recommend.

If you're MAC does not have a policy or a coding recommendation. It is recommended that you have your Medicare patients sign an Advance Beneficiary Notice (ABN form CMS-R-131) for non-covered services.

**Reporting ICD-9 Codes for Adjustments:**

**QUESTION:** What are the guidelines for reporting ICD-9 CM codes on claim forms submitted to payors for adjustments to the gastric band?

**ANSWER:** The payor community states that services and procedures rendered to patients are coded and billed based on medical necessity. This means that the diagnosis is justified as reasonable, necessary and/or appropriate, based on documentation. The primary diagnosis should be the reason(s) for the visit (chief complaint) such as overeating (783.6), followed by the condition(s) that put the patient at risk for complications, such as morbid obesity, obesity, hypertension, diabetes, or cardiovascular disease. These conditions must be documented in the History of Presenting problem (HPI).

An example of this is:

CC: Overeating

HPI: Follow-up visit for post gastric band. Patient has a history of morbid obesity...

**Reportable ICD-9-CM codes:**

783.6 (over eating)

278.01 (morbid obesity)

V- Code (BMI)

V45.86 (status post bariatric surgery):

**Coding Options for Band Adjustments:**

Description	CPT Codes
E & M Establish patient	99211 - 99215
New Pt. had band placement performed by surgeon  Not performing the adjustment – E & M	99201 -99205
Fluoroscopic guidance for needle placement (aspiration, injection, localization of device)  Modifier(s) may apply (when performed in combination with Radiologist)	77002  -26/TC
Ultrasonic guidance for needle placement (e.g. Biopsy, aspiration, injection, localization devise), imaging supervision and interpretation	76942

Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, without KUB	74246
Lap-Band Adjustment only *	S2083**
Laparoscopic) adjustment of size of adjustable gastric restrictive device. Infusion of saline for device tightening/ withdrawal of saline for device loosening	S2083
<b>Code also any:</b>	
<b>Abdominal ultrasound</b>	77002
<b>Fluoroscopy</b>	76700
<b>Barium swallow</b>	
Office visit and Lap-Band Adjustment	99211-99215-25
Decision for adjustment must be made on the same day of adjustment  (follow appropriate coding rules for modifier -25)	S2083

\*\* S codes are national codes (non-Medicare) created by the Blues which other payers have adopted.

\* If the payer does not recognize S2083, these are alternative codes to use:

Unlisted Procedure of the stomach  Use when there is no payer designated CPT code  In the comment field on your CMS 1500 form (box 19)  Type "Gastric Band Adjustment"	43999
Office visit and Injection  (decision for adjustment must be made on the same day of adjustment)  if the sole purpose for the visit is adjustment an E & M code cannot be billed	99211-99215-25  43999

<p><b>Miscellaneous Supply codes</b></p> <p><b>May NOT be billed with S2083 code</b></p>	
<p><b>Fitting and adjustment of gastric band</b></p> <p>(Intended for use to indicate a reason for care in patients who may have already been treated for some disease or injury not now present. V code should be used only as a supplementary code and should not be the one selected for use in primary)</p>	<p><b>V53.51</b></p>

**Use of Fluoroscopy with Medicare patients:**

**QUESTION:** I recently had a patient with a suspected LapBand port/tubing leak. We had the patient meet the surgeon in Radiology the next morning and the surgeon injected the port with radiopaque dye under Fluoro to confirm leak. We have been unable to find a diagnosis code that Medicare will accept for billing. We have billed the procedure as a Fluoroscopy. We have tried 996.59; 560.9; 996.7; and 278.01. Any suggestions would be appreciated as my billing department needs to close this at the end of this week.

**ANSWER:** There are perhaps a couple of things going on here. The CPT code 76000 has professional and technical components. Do we know if the fluoroscopy was performed in the hospital? If so the hospital may have already billed for the procedure and all that is need for the physician supervision is the modifier 26. On the other hand it is also Medicare and they too have policy. [http://medicare.fcso.com/Coverage Find LCDs and NCDs/](http://medicare.fcso.com/Coverage_Find_LCDs_and_NCDs/). If it is Florida can the follow this link to see if there is specific policy for this CPT and ICD-9 codes. I would think the codes that they used for ICD-9 diagnosis codes (not morbid obesity however) should have been okay.

I think that perhaps it may have something to do with where the service was provided and the components of this service may need to be split for reimbursement.

One last thing, having a copy of the claim form with the Medicare denial codes would most likely really tell them what claim is lacking. In addition calling Medicare (Their MAC) customer service could also specifically they them why the claim was denied. Sometime the denial codes are vague.

**RVU for code S2083:**

**QUESTION:** Is there a WRVU rate tied to the S2083 code for band fill adjustments on the adjustable lap bands?

**ANSWER:** RVU's are determined by geographic area. The two most common CPT codes used for Band Adjustment, (S2083 and 43999) Do not have assigned RVU's (see attached) 43999 is an unlisted procedure and S2083 is a Temporary HCPCS code. Because these codes do not carry a value each payer, including Medicare (if

there is coverage) determines what the appropriate reimbursement is for the condition reported at the time of service.

**QUESTION:** When a surgeon is employed by a hospital / multi-specialty medical group, the surgeon's compensation contract may be dependent on RVUs and not on actual collections. It is understood that band adjustments do not have a CPT code (except nonspecific 43999 or S2083) and thus no relative value unit (RVU) but they are billable, take time (and used supplies in the office) and typically bring in some form of payment. Have any surgeons been successful in working with the hospital in establishing a way for the surgeon to be "credited" and thus compensated for an adjustment? Can you think of any other procedure in which this would be relevant (to provide a working comparison)?

**ANSWER:** Usually for purposes of calculating WRVU the procedure is mapped to known CPT code for convenience. There are multiple ways to solve this problem.

Typically what we recommend in order to establish value for a non-RVU code is to evaluate RVU's associated with other similar procedures. In this case, I think injection codes are going to be the most similar in time and intensity. For example, you could look at 67028, which is an injection code for eye care. The total RVU's are 3.7800 with the WRVU component being 1.4400. Because the time and intensity are relatively short and low, the WRVU will be less, which is theory would be similar to a band adjustment. The MD is still getting the WRVU component of the E/M code, which takes more time than the actual adjustment procedure.

I think the answer is to discuss between parties and come up with a fair market value of similar procedures. When working with a facility to determine appropriate compensation for WRVU's associated with adjustments, it is important that similar procedures are evaluated to come up with a fair market value in which to compensate for the adjustment based on WRVU, and that both parties agree to this. It is not going to be much, though; probably 0.5-1.5 WRVU's

**QUESTION:** Why is there no specific CPT code for an adjustment of the gastric band?

**ANSWER:** When the society approached the AMA for a CPT code for adjustments, they were unable to get a fair RVU for this service. So the society elected/decided not to obtain one. Therefore, it is left up to the payer to assign a CPT and or HCPCs code that is payable. Most of the major carriers have adopted HCPCs code S2083 as well as most of the major payers have written right in the bariatric surgery policy the CPT/HCPCs code to bill.

## **2. Hiatal Hernia repair during band placement**

### **Coding for Hiatal Hernia Repair associated to a Bariatric Procedure**

**QUESTION:** What is the proper way to bill hiatal hernia repair with placement of the gastric band?

**ANSWER:** There are several possible coding scenarios, but most importantly you need to query your surgeon as to the type of hiatal hernia repair he/she is expecting to perform at the time of Gastric Band placement. The appropriate CPT and ICD-9 diagnosis codes would be included in your letter of medical necessity to the insurance company for approval along with Gastric Band placement codes.

The Gastric Band placement would be your primary code and hiatal hernia as the second procedure utilizing the modifier -51 (multiple procedures) with the hiatal hernia CPT code (if reporting to Medicare modifier -51 is not needed).

CPT does not contain a specific code to describe laparoscopic hiatal hernia repair.

Therefore, to describe a procedure of this type, you need to select the unlisted procedure code 39599 (Unlisted procedure, diaphragm.)

Other possible options are the following:

A hiatal hernia repair is an intrinsic component of CPT code 43280, which includes a fundoplasty and crural repair. If a surgeon finds a hiatal hernia, this code can be used with the appropriate reduced service modifier (-52) and a good documentation in the operative report. Another option is to add the complex modifier (-22) to the bariatric procedure CPT code and describe the complexity of the procedure by adding the hiatal hernia repair.

It is not acceptable to use the paraesophageal hernia repair code. A paraesophageal hernia is a far more serious condition than a regular hiatal hernia. If one is encountered then use 39502 (open repair) or 43281 (laparoscopic repair without mesh)/43282 (laparoscopic repair with mesh.)

When looking for an appropriate CPT code it is possible not always to find the exact wording. In this case look for the CPT code that best describes the procedure performed as dictated in the operative report.

### 3. Sleeve Gastrectomy

#### **Sleeve Gastrectomy ICD-9 Coding and DRG Mapping – effective October 1, 2011 New Ruling Published**

**Issue:** The laparoscopic sleeve gastrectomy procedure (CPT code 43775) for the surgical treatment of obesity had an ICD-9 procedure code (43.89) that is not mapped to the obesity surgery DRG codes 619-621 when the patient diagnosis is morbid obesity (278.01). And actually, this diagnosis code was not assigned to any DRG, so as a default the mapping automatically assigned an “unrelated” OR DRG (DRG’s 981-983). This lack of appropriate DRG assignment was reflected in the MS-DRG software used by many hospitals and insurance companies. This issue created confusion and inappropriate coding or reimbursement issues with this procedure in some hospitals. In November 2010, the ASMBS requested CMS to address this issue and assign the appropriate obesity surgery DRG’s 619-621 to the sleeve gastrectomy ICD-9 code (43.89).

**CMS New Ruling:** The HIPPS (Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals) final rule display copy was published earlier this week with information about the revised ICD-9 codes for laparoscopic and open sleeve gastrectomy. Effective October 1, 2011, CMS will be assigning Laparoscopic Sleeve Gastrectomy to ICD 43.82 and Open Sleeve Gastrectomy to ICD 43.89. Both of these ICD-9 codes will be grouped to DRG 619, 620 and 621 (OR procedures for obesity).

It is important to note that laparoscopic sleeve gastrectomy remains a nonapproved procedure by CMS National Coverage Determination. So, the procedure code 43.82 will be added to the “Noncovered Procedures” edit of the Medicare Code Editor (MCE). Because procedure code 43.89 includes several gastrectomy procedures, its inclusion in the MCE would be inappropriate. Therefore, it will not be placed on the MCE.

We expect the update on the MS-DRG software to be applied later this year and solve any confusion and inappropriate coding and reimbursement issues with this procedure.

**Assistant Surgeon Modifier 80 "crosswalk" for CPT code 43775 (Laparoscopic sleeve gastrectomy)**

**Issue:** Some Insurance companies are not allowing the use of modifier 80 (use of an assistant surgeon) for the laparoscopic sleeve gastrectomy CPT code. One of the reasons is because Medicare does not cover this CPT code, so it has not been appropriately crosswalked with the ability to use modifier 80

Ingenix Revenue Code Crosswalk is a software system used to crosswalk all CPT and HCPCS Level II Codes to all relevant revenue codes. It is the most common crosswalk system used by major payors and CMS. On their update, effective July 1, 2011, Ingenix crosswalk for CPT code 43775 will have added Modifier 80.

**Definition of modifier 80:** Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

**AMA guidelines:** One physician assists another physician in performing a procedure. If an assistant surgeon assists a primary surgeon and is present for the entire operation or a substantial portion of the operation, the assisting physician reports the same surgical procedure as the operating surgeon. The operating surgeon does not append a modifier to the procedure that he or she reports. The assistant surgeon reports the same CPT code as the operating physician, with modifier 80 appended.

The Medicare Physician Fee Schedule (MPFS) does not cover the code 43775 and subsequently does not assign modifier values for this code. Work is being done to encourage Medicare to review and update their modifier policy for this CPT code 43775.

The update on Ingenix's crosswalk adding the modifier 80, will allow access to the users to support the modifier being used with 43775. This evidence can be used to support its use when reviewing a case with insurance companies.

**QUESTION:** What needs to be done to get Medicare to pay for the sleeve?

**ANSWER:** In order for Medicare to start covering Sleeve Gastrectomy, the NCD (National Coverage Determination) will have to be formally reopened. This is a potentially complex procedure. Following internal discussion within the ASMBS leadership as well as consultation with industry partners we have concluded that we will delay our request to reopen the NCD until the definition of the coverage issues relevant to healthcare reform/states insurance exchanges is better defined.

**QUESTION:** Our coders are asking if there is also a 2010 code for 'open' VSG or does the 43775 code cover both laparoscopic and open?

**ANSWER:** There is no specific new code for "open vertical sleeve gastrectomy". 43775 is a laparoscopic code. The code 43843 (Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical banded gastroplasty) can be used for this open cases.

**QUESTION:** I've had a question come up on what CPT code to use for a laparoscopic sleeve Gastrectomy when the procedure is being done as a staged procedure. Could you or the insurance committee help us determine the best code to use with this?



**ANSWER:** If the sleeve gastrectomy is being done as the first stage, still need to code each operation separate.

1st Stage: lap sleeve gastrectomy 43775

2nd stage: lap gastric bypass 43644 or lap BPD, DS 43659 (unlisted laparoscopy, stomach) -51 modifier for complex procedure with appropriate documentation

#### 4. BPD/DS

**QUESTION:** How should I code a request for a staged BPD w/ DS?

**ANSWER:** If the first stage is a sleeve gastrectomy, then request code 43775 (laparoscopic) or 43843 (open). On the second stage, if it is a completion laparoscopic DS use 43659 and describe the procedure; for an open use 43845 with a reduced service modifier -52 and describe the procedure as well.

#### 5. Revisional Procedures and Other Scenarios

**QUESTION:** My doctor performs about 10-11 laparoscopic bariatric surgeries per week. On many of these cases he also performs laparoscopic enterolysis. I use the CPT code 44180 and usually apply a 79 modifier (I used to use the 59 modifier). It is almost impossible to get this paid. I am appealing the insurance companies 2 and 3 times. I have started adding a 22 modifier along with the 79 modifier to the 44180 and sending the operative report and a Letter of Medical Necessity explaining the lysis. I do this in hopes of not getting denied. So far, I'm not having much luck. The insurance companies bundle the bariatric procedure and the lysis. By applying the 79 modifier I try to unbundle them. I don't want to commit insurance fraud. My doctor insists that the lysis should be paid.

**ANSWER:** The coding rule is: CCI edits (Correct Coding Initiative) which Medicare and many commercial payers use for adjudicating claims state: Code 44180 is a component of Column 1 which includes code 43644 and cannot be billed using any modifier Modifier 79 is an Unrelated Procedure or Service by the Same Physician during the Postoperative Period. Clearly, as stated above, 44180 is part of procedure code 43644. Modifier 22, Increased Procedural Services: When the work required providing a service is substantially greater than typically required. This modifier is also not appropriate, unless you can substantiate by documentation that there were extensive adhesions which increased the procedural service considerably. Even then, the modifier does not guarantee payment.

I recommend you obtain a copy of the CCI edits. Alternatively, purchase a software program that offers code validation, using CCI edits. The payer community, like Aetna, United HealthCare for example have available on their website, McKesson claim auditing software which allows you to check your CPT codes prior to submitting claims to ensure you are not violating any of the CCI edits.

Unbundling routinely, could have serious repercussions with Medicare and the payer community.

**QUESTION:** I have performed laparoscopic internal hernia repairs on patients who were found to have herniated bowel through Petersen's space defect and were having abdominal pain. Sometimes in conjunction with laparoscopic cholecystectomy and sometimes lap internal hernia repair alone. I would like to know if insurance companies/Medicare/Medicaid reimburses that procedure and how to code for them. I have used the code

"49659" (unlisted laparoscopy procedure, hernioplasty, herniorraphy, herniotomy) but have not been reimbursed yet.

**Answer:** You can use the following codes if indicated and depending of what was done during the internal hernia repair:

44050 Reduction of volvulus, intussusceptions, internal hernia

44180 Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion)

44850 Suture of mesentery (separate procedure)

44202 Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis

**QUESTION:** I am wondering if you could give me any guidance as to a best diagnosis code to use for a slip of the LAP-BAND. We have been using 997.4 for unspecified digestive system complications.

**ANSWER:** Use whatever is documented (i.e. symptom or whatever x-rays shows, herniated stomach for example. Not having the progress note available it is difficult to say) in addition to one or both of these if applicable.

996.70 Other complications of internal device/implant

996.59 Mechanical complication due to implant and internal device, not elsewhere classified

787.2 Difficulty swallowing/Dysphagia

787.1 Heartburn

530.81 Reflux

553.3 Hiatal Hernia

537.0 Gastric Outlet Obstruction

536.2 Persistent vomiting

787.03 Regurgitation/vomiting

V45.86 Bariatric Surgery status

536.8 Dilatation of gastric pouch

**QUESTION:** What codes would you use for diagnosis of stricture at gastrojejunostomy, necessitating a laparoscopic gastrojejunostomy revision (stricturoplasty)?

**ANSWER:** You can use CPT code 43860 Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastectomy or intestine resection; without vagotomy

Facility procedure codes: 43.7, 44.02, 44.00, 44.03, 44.01, 44.39

ICD-9 code: 537.0 Gastric outlet obstruction/stenosis

As stricturoplasty for this doesn't have a specific code, the other option is to use the unlisted laparoscopy stomach (43659) and intestine (44238) codes.

## **6. Insurance Authorization, Appeals, etc.**

### **Appeal for a revisional procedure on a patient with BMI less than 35 kg/m<sup>2</sup>**

**QUESTION:** What to do when a patient had the gastric band removed due to an unexpected event (i.e., stomach perforation during band reposition, unrelated colon perforation with band contamination, etc.) and now is back for a new bariatric procedure but his/her BMI is under 35?

**ANSWER:** While some payers try to insist that their medical criteria for a primary case must be met, this is not always in the best interests of the patient. This patient should not have to wait until regaining weight to a BMI of 35 or above because the band explant was due to either a technical failure (prolapsed) in tandem with the need to remove the band at the time of repairing the perforation or an unrelated emergency surgical infection that contaminated the band.

When placement of a new gastric band is in the patient's best interests, regardless of the payer's medical policy on revisions, an insurance preauthorization for the revision should be submitted immediately (presuming patient is medically stable, etc.). The patient should be educated to expect a possible insurance denial understanding also that the provider can attempt a "peer to peer" provider appeal, and the patient can expect the need to also request a member (patient) appeal (which is separate from a provider appeal).

Revisions performed despite a BMI below 35 can be approved on appeal quite frequently when the provider and the patient have a coordinated strategy focusing on the patient's medical need rather than an insurance company's inappropriate medical policy.

**Bariatric Coding Email Hotline: Please send your questions to the following email: [insurance@asmbs.org](mailto:insurance@asmbs.org).**