2020 Bariatric Reimbursement Fact Sheet

Finding the appropriate ICD-10-PCS Code[1]

STEP 1: Select the characters below that best describe the procedure and associated body part.

Procedure Code	Description (Includes Body Part)	Procedure Code	Description (Includes Body Part)
0D16	Bypass / Stomach	0DV6	Restriction / Stomach
0D19	Bypass / Duodenum	0DW6	Revision / Stomach
0D1A	Bypass / Jejunum	0DY6	Transplantation / Stomach
0D1B	Bypass / Ileum	0F19	Bypass / Common Bile Duct
0D76	Dilation / Stomach	3E0G	Introduction / Upper GI
0DB6	Excision / Stomach	BD11	Fluoroscopy / Esophagus
0DB8	Excision / Small Intestine	BD12	Fluoroscopy / Stomach
0DB9	Excision / Duodenum	BD13	Fluoroscopy / Small Bowel
0DBB	Excision / Ileum	BD14	Fluoroscopy / Colon
0DF6	Fragmentation / Stomach	BD15	Fluoroscopy / Upper GI
0DH6	Insertion / Stomach	BD16	Fluoroscopy / Upper GI and Small Bowel
0DL6	Occlusion / Stomach	BD19	Fluoroscopy / Duodenum
0DL7	Occlusion / Stomach, Pylorus	BF0C	Plain Radiography / Hepatobiliary System, All
0DM6	Reattachment / Stomach	BF18	Fluoroscopy / Pancreatic Ducts
0DN6	Release / Stomach	BW00	Plain Radiography of Abdomen
0DP6	Removal / Stomach	BW01	Plain Radiography of Abdomen and Pelvis
0DQ6	Repair / Stomach	BW11	Fluoroscopy / Abdomen and Pelvis
0DU6	Supplement / Stomach		

STEP 2: Using your coding reference book or software, select the 3 characters that best describe the associated approach, device and qualifier in the respective order.

Given the large number of individual procedure codes available for bariatric procedures, please refer to your coding reference book or coding software to look up the associated Approach, Device and Qualifier that best align to the procedure code and body part you identified in Step 1 above.

STEP 3: Combine the characters from Steps 1 and 2 in the respective order from left to right. This is your ICD-10-PCS Code.

For example, the code for **Excision of Stomach, Percutaneous Endoscopic Approach (0DB64Z3)** would be created in the steps below:

Example: **STEP 1:** 0DB6 **+** **STEP 2:** Approach 4 **+** Device Z **+** Qualifier 3 **=** **STEP 3:** **0DB64Z3**

Surgeon CPT, APC & DRG Codes

Surgeon CPT Code[2]	Procedure	Surgeon Nat Average Medicare Payment[3]
	Laparoscopic Gastric Bypass	
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (Roux limb 150cm or less)	$ 1,829
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	$ 1,947
	Laparoscopic Gastric Banding	
43770	Laparoscopy, surgical, gastric restrictive procedure: placement of adjustable gastric restrictive device (gastric band and subcutaneous port components) (For individual component placement, report 43770 with modifier 52)	$ 1,184
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	$ 1,345
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	$ 1,001
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	$ 1,345
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	$ 1,011
	Laparoscopic Sleeve Gastrectomy	
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)	$ 1,175
	Miscellaneous Gastric Procedure (including revisions)	
43659	Unlisted laparoscopy procedure, stomach	Carrier Priced
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	Not Covered By Medicare
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	$ 1,350
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)	$ 2,050
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150cm or less) Roux-en-Y gastroenterostomy	$ 1,710
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	$1,902
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	$ 2,039
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy	$ 1,722
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy	$ 1,802
43886	Gastric reconstructive procedure, open; revision of subcutaneous port component only	$ 382
43887	Gastric reconstructive procedure, open; removal of subcutaneous port component only	$ 344
43888	Gastric reconstructive procedure, open; removal and replacement of subcutaneous port component only	$ 486
43999	Unlisted procedure, stomach	Carrier Priced
77002-26	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)	$ 28
74246-26	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	$ 46
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline	Carrier Priced

NOTE: HCPCS S-codes are not recognized by Medicare, but are used by some commercial plans.

Document Body Mass Index (BMI) as an exact number and not a range. BMI can be documented by billing CPT 3008F and the appropriate ICD-10 Z code. Adding the BMI to the claim helps to decrease the number of chart reviews needed throughout the year and during the HEDIS® collection season. Greater precision in charting the member's BMI will help members achieve or remain at a healthy weight. Appropriate BMI Codes can be found in ICD-10-CM Z68 section.

Surgeon CPT, APC & DRG Codes (continued)

Outpatient Facility
Hospital Outpatient Department

APC	APC Description	Status	Nat Average Medicare Payment[4]
5054	Level 4 Skin Procedures [CPT code: 43887]	T	$ 1,623
5055	Level 5 Skin Procedures [CPT codes: 43886, 43887, 43888]	T	$ 2,977
5301	Level 1 Upper GI Procedures [CPT code: 43999]	T	$ 786
5361	Level 1 Laparoscopy and Related Services [CPT code: 43659, 43773]	J1	$ 4,596
5362	Level 2 Laparoscopy and Related Services [CPT code: 43770]	J1	$ 8,412
5571	Level 1 Imaging with Contrast [CPT code: 74246]	Q1	$ 182
5303	Level 3 Upper GI Procedures [CPT code: 43774]	J1	$ 2,999
N/A	Inpatient Only [CPT codes: 43644, 43645, 42772, 43775, 43843, 43845, 43846, 43847, 43848, 43860, 43865]	C	Inpatient Only
N/A	Code 43843 is excluded, not payable by Medicare.	E1	Not covered by Medicare
5303	Level 3 Upper GI Procedures [CPT code: 43774]	J1	$ 2,999

Freestanding Ambulatory Surgery Center

CPT CODE[2]	Description	Nat Average Medicare Payment[4]
43886	Gastric reconstructive procedure, open; revision of subcutaneous port component only	$ 1,504
43887	Gastric reconstructive procedure, open; removal of subcutaneous port component only	$ 820
43888	Gastric reconstructive procedure, open; removal of subcutaneous port component only	$ 1,504
74246	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	$ 104

INPATIENT FACILITY

DRG	Description*	Average Length of Stay (Days)[5]	National Average DRG Payment[5]
	Inpatient Facility		
619	O.R. procedures for obesity with MCC	5.1	$ 19,282
620	O.R. procedures for obesity with CC	2.3	$ 11,240
621	O.R. procedures for obesity without CC/MCC	1.6	$ 9,847
987	Non-extensive O.R. procedure unrelated to principal diagnosis with MCC	10.5	$20,881
988	Non-extensive O.R. procedure unrelated to principal diagnosis with CC	5.7	$ 10,763
989	Nonextensive O.R. procedure unrelated to principal diagnosis without CC/MCC	3.2	$ 7,218

NOTE: FY 2020 is effective October 1, 2019 for Inpatient Hospital DRGs. ICD-10 codes are grouped into Diagnoses Related Groups (DRG s) for Medicare reimbursement using a patient's diagnoses, procedures performed, age, sex and discharge status, among other factors. One DRG per patient is assigned to each inpatient stay. Some providers may be paid based on a methodology which differs from the standard MS-DRG calculation reflected in the amount shown (i.e., rural referral centers, hospitals in the state of Maryland).

*CC stands for Complications and Comorbidities while MCC refers to Major Complications and Comorbidities. These are a measure of the severity of an illness indicating additional diagnoses present on a case that may increase the expected resource consumption beyond that of the same case without a CC or MCC under the current Medicare definition. Whether a complication or comorbidity is classified as a CC or MCC is defined by Medicare.

Surgeon HCPCS Codes

	SUPPLY CODES – BAND ADJUSTMENTS
A4208	Syringe with needle, sterile 3cc, each
A4215	Needle, sterile, any size, each
J7030	Infusion, normal saline, solution 1,000cc
J7040	Infusion, normal saline
J7050	Infusion, normal saline, solution 250cc

1. ICD-10 Procedural Coding System (ICD-10-PCS) is developed and maintained by the Centers for Medicare and Medicaid Services (CMS). 2. All Current Procedural Terminology (CPT) five digit numeric codes, descriptions, numeric modifiers, instructions, guidelines and other material are copyright 2019 American Medical Association. 3. CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B (CMS-1715-F); Addendum B. All MPFS Fee Schedules calculated using CF of $36.0896 effective January 2020. 4. CY 2020 Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1717-FC); Addendum B and Final ASC Addenda AA 5. Medicare Inpatient Prospective Payment System Final Rule [CMS-1616-F], Federal Register (Vol. 84, Issue 159), Friday, August 16, 2019; Final: National Average DRG Payment.

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