

# 2022 Bariatric Reimbursement Guide

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## Finding the appropriate ICD-10-PCS Code<sup>1</sup>

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	3E0G	Introduction / Upper GI
0D19	Bypass / Duodenum	BD11	Fluoroscopy / Esophagus
0D2W	Device Change, Peritoneum	BD12	Fluoroscopy / Stomach
0DB6	Excision / Stomach	BD13	Fluoroscopy / Small Bowel
0DB9	Excision / Duodenum	BD14	Fluoroscopy / Colon
0DP6	Removal / Stomach	BD15	Fluoroscopy / Upper GI
0DQ6	Repair / Stomach	BD16	Fluoroscopy / Upper GI and Small Bowel
0DU6	Supplement / Stomach	BD19	Fluoroscopy / Duodenum
0DV6	Restriction / Stomach	BF0C	Plain Radiography / Hepatobiliary System, All
0DW6	Revision / Stomach	BF18	Fluoroscopy / Pancreatic Ducts
0F19	Bypass / Common Bile Duct	BW00	Plain Radiography of Abdomen
0W2G	Device Change, Peritoneal Cavity	BW01	Plain Radiography of Abdomen and Pelvis
		BW11	Fluoroscopy / Abdomen and Pelvis

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 <sup>2</sup>	Procedure	Surgeon Nat Average Medicare Payment <sup>3</sup>
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## Laparoscopic Gastric Bypass

43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (Roux limb 150cm or less)	\$ 1,793
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	\$ 1,896

## 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)	\$ 1,167
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	\$ 1,324
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	\$ 982
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	\$ 1,324
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	\$ 994

## Laparoscopic Sleeve Gastrectomy

43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)	\$ 1,143
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## 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	\$ 1,170
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	\$ 1,329
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)	\$ 2,017
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150cm or less) Roux-en-Y gastroenterostomy	\$ 1,708
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	\$ 1,869
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	\$ 1,992
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy	\$ 1,688
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy	\$ 1,766
43886	Gastric reconstructive procedure, open; revision of subcutaneous port component only	\$ 382
43887	Gastric reconstructive procedure, open; removal of subcutaneous port component only	\$ 345
43888	Gastric reconstructive procedure, open; removal and replacement of subcutaneous port component only	\$ 483
43999	Unlisted procedure, stomach	Carrier Priced
77002-26	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)	\$ 27
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	\$ 44

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 <sup>4</sup>
5054	Level 4 Skin Procedures [CPT code: 43887]	Q2	\$ 1,749
5055	Level 5 Skin Procedures [CPT codes: 43886, 43888]	T	\$ 3,596
5301	Level 1 Upper GI Procedures [CPT code: 43999]	T	\$ 826
5361	Level 1 Laparoscopy and Related Services [CPT code: 43659, 43773]	J1	\$ 5,168
5362	Level 2 Laparoscopy and Related Services [CPT code: 43770]	J1	\$ 9,096
5571	Level 1 Imaging with Contrast [CPT code: 74246]	Q2	\$ 182
5303	Level 3 Upper GI Procedures [CPT code: 43772, 43774]	J1	\$ 3,136
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

### Freestanding Ambulatory Surgery Center

CPT CODE <sup>2</sup>	Description	Nat Average Medicare Payment <sup>4</sup>
43886	Gastric reconstructive procedure, open; revision of subcutaneous port component only	\$ 1,824
43887	Gastric reconstructive procedure, open; removal of subcutaneous port component only	\$ 887
43888	Gastric reconstructive procedure, open; removal of subcutaneous port component only	\$ 1,824

### INPATIENT FACILITY

DRG	Description*	Average Length of Stay (Days) <sup>5</sup>	National Average DRG Payment <sup>5</sup>
619	O.R. procedures for obesity with MCC	2.8	\$ 20,190
620	O.R. procedures for obesity with CC	1.8	\$ 11,624
621	O.R. procedures for obesity without CC/MCC	1.4	\$ 10,532
987	Non-extensive O.R. procedure unrelated to principal diagnosis with MCC	7.7	\$ 21,602
988	Non-extensive O.R. procedure unrelated to principal diagnosis with CC	4.3	\$ 11,253
989	Nonextensive O.R. procedure unrelated to principal diagnosis without CC/MCC	2.3	\$ 7,409

NOTE: FY 2022 is effective October 1, 2021 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 2021 American Medical Association. 3. CY 2022 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B (CMS-1751-F, Vol. 86, No. 221; November 19, 2021); Addendum B. All MPFS Fee Schedules calculated using CF of \$34.6062 effective January 2022. 4. CY 2022 Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1753-F, Vol. 86, No. 218; November 16, 2021); Addendum B and Final ASC Addenda AA. 5. Medicare Inpatient Prospective Payment System Final Rule [CMS-1752-F], Federal Register (Vol. 86, Issue 154), Friday, August 13, 2021; Final: National Average DRG Payment.

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