***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 payors' 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 payor'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.*

This Bariatric Surgery Insurance Coding Toolkit was created on behalf of the American Society for Metabolic and Bariatric Surgery by the ASMBS Insurance Committee

Introduction: The American Medical Association maintains a list of Current Procedure Terminology (CPT) codes that describe over 10,000 procedures and Evaluation and Management (E/M) categories of inpatient and outpatient-based visits. Each code has a detailed and specific definition of what is included within the procedure. Each CPT code is valued by a separate group, the RVS Update Committee. Each code has three components within the valuation, with the most relevant one to an RVU-based physician being the work RVU or wRVU. The wRVU is intended to take into account the amount and complexity of work spent pre-operatively, intra-operatively, and all post-operative care within the global period. One operation may take a similar amount of time intra-operatively but have a higher work RVU because of the intra-operative complexity or risk, as well as the amount of post-operative care involved. CPT code valuations are published annually by the Centers for Medicare and Medicaid Services (CMS) in the Physician Fee Schedule. Current values for individual and groups of CPT codes can be queried here at the CMS website at: https://www.cms.gov/medicare/physician-fee-schedule/search/overview

Insurance companies and CMS have rules about what procedures can be performed concurrently or in a patient's lifetime. For example, CMS will only pay for one appendectomy in a patient's lifetime. A common scenario for general and bariatric surgeons is the exclusion of concurrent billing of an adhesiolysis in addition to the primary code for an intra-abdominal procedure. These fall under the National Correct Coding Initiative Edits, preventing payment for specific combinations of procedures when reported together. In addition, procedures cannot be broke down into additional components in order to bill for additional procedures. This would be referred to as

“unbundling.” A paraesophageal hernia repair code such as 43281 would include the performing of a fundoplication.

A procedure code that most completely represents the performed procedure should be selected. Some insurance companies may consider different codes to be bundled together compared to others. Common examples would include repair of a paraesophageal hernia (type 2-4) or repair of a ventral/incisional hernia. For a paraesophageal hernia to be reimbursed in conjunction with a bariatric procedure, there must be proper documentation of the extent of dissection and repair performed. The placement of sutures without an appropriate mediastinal dissection and esophageal mobilization would not be considered a formal repair and would not be reimbursed. Pre-operative documentation of the presence of a paraesophageal hernia and pre-authorization of the code may assist with reimbursement for such a hernia, although some insurers will not reimburse it regardless. There is more detailed information in a separate ASMBS handout for hiatal hernia repairs.

For an incisional hernia to be separately coded and billed, it cannot simply be incidental to the primary procedure. If an incision (laparoscopic or laparotomy) goes directly through a hernia, then its closure is mandated by virtue of the fact that that incision had to be closed anyway. If additional incisions and procedural work are performed, then the hernia repair may qualify as an additional procedure. There are different codes for congenital hernias such as an umbilical or inguinal versus an incisional hernia, and there are often further divisions of these codes if the hernia is primary/recurrent or reducible/incarcerated. Proper description of the hernia and the repair performed will ensure proper reimbursement. Performing an esophagogastroduodenoscopy (EGD) or esophagogastrojejunoscopy during an additional procedure may or may not be reimbursed. If the endoscopy was performed to ensure that the primary procedure was done properly (e.g., ensure anastomotic patency or assess for hemostasis or leak), then it is not likely to be reimbursed as it would be included in the primary procedure. If the endoscopy was done for diagnostic purposes in conjunction with another procedure, then that must be properly described and billed with an appropriate diagnosis code and modifier.

The majority of primary bariatric procedures fall into readily described codes, which are listed below. However, as new procedures arise, there can be difficulty in adequately describing the procedures. Although a CPT code exists for the open biliopancreatic diversion with duodenal switch, there is no CPT code for the laparoscopic procedure, performed in the traditional divided format or the single anastomosis technique (SADI-S). There are also many laparoscopic revisional procedures that do not have individual codes. The full process for adding new codes is extensive, and this discussion is beyond the scope of this toolkit, but it is something the ASMBS seeks when appropriate. For a procedure that is relatively rare, it may never receive its own CPT code. For a

procedure that is increasing in use, it may begin the process of receiving its own CPT code.

Procedures without a specific CPT code should generally be described with the appropriate unlisted CPT code. For unlisted codes, there are no formally published guidelines for coding procedures, as the codes are intended to be generic. There will be some variation between professional coders and different payors. There may be additional ways to code a procedure, but the recommended unlisted codes are intended to be fairly widely accepted methods of coding a procedure.

Keep in mind, that some revisional bariatric procedures may fall under the description of an existing code. This will depend on your technique and should be reviewed with your coding team. Using standard codes will simplify your coding and reimbursement timeline. One example would be a laparoscopic resection and re-creation of an entero-enterostomy. This is a resection of two separate pieces of intestine (e.g., the Roux/common channel segment and the biliopancreatic segment), and two separate anastomoses. There is a code for a laparoscopic small bowel resection (44202) and each additional segment (44203).

If a procedure did not involve additional procedures but was nevertheless markedly more difficult than usual, it may qualify for a -22 modifier for increased reimbursement. This should not be used excessively and will require documentation for why it was more difficult. This documentation should include description of the additional work required and why that work was required. Time may be an indication of additional work, but simply saying “Enterolysis for greater than 1 hour” does not describe why it was more difficult. There is no specific threshold of time to be crossed in order to justify a -22 modifier.

There are many additional modifiers, but some of them are particularly relevant to a surgeon. If you see patient in clinic and schedule them for an elective procedure in the future, that is considered your “decision to operate.” When you see them again the day of surgery or a week or two before the operation, you have already made the decision to operate and cannot bill for an E/M evaluation at that time. In fact, the activities and care for that patient starting 24 hours prior to the operation and for the duration of the global period is included. The hospital/facility may require an updated history and physical (H&P), but this cannot be billed. Therefore, the forms are often fairly brief and may be built-in templates in your medical record or endoscopy software.

However, if you see a patient in clinic or the hospital, and you determine that they will need an operation or procedure that day, that E/M evaluation can be billed for. You will need a modifier so that it is not discarded as a routine pre-operative H&P. For a minor

procedure or endoscopy, you would use the -25 modifier. For a major operation, you would use the -57 modifier.

The following are several other scenarios that a bariatric surgeon may encounter, often pertaining to a patient having a procedure done at another facility. Remember that there is a 90-day global period after all bariatric codes, during which all routine post-operative care cannot be billed for. CMS and private payors can have slightly different rules about what kind of care or procedures can be billed for, so these examples are not comprehensive.

Example 1: A patient presents to your hospital two weeks after bariatric surgery done at another institution and is now admitted for dehydration. You would use the modifier -55 for postoperative management only. If the surgeon who did the procedure is in your group or is in your call coverage pool, then you cannot bill for anything other than an additional procedure or operation.

Example 2: A patient presents to your hospital two weeks after bariatric surgery done at your institution and is now admitted for a leak and needs a diagnostic laparoscopy, EGD and surgical drainage. You would use modifier -57 for the decision to operate, as well as modifier -78 for an unplanned return to the operating room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period.

Example 3: A patient needs an appendectomy or cholecystectomy within 90 days of their bariatric operation. You would use modifier -79 for an unrelated procedure by the same physician or other qualified healthcare provider during the postoperative period

Example 4: A complex case requires two surgeons, and you work at an institution with residents. In that case, you need to document that there was either no resident available, or that the resident that was available was not qualified to assist. A single phrase that would accomplish this is “No qualified resident was available to assist with this case.” You would then want to elaborate on why the second surgeon was necessary, such as complex anatomy or need for their assistance in dissection or creating an anastomosis. You would use modifier -80 for an assistant surgeon.

Example 5: If you have a patient with a severe leak or similar that requires serial take backs to the OR, you may need to use modifier -58 for staged or related procedure or service by the same physician during postoperative period. Some payors may require this, and others may simply pay for any other operations even within the global period.

Operation	Description	CPT® Codes	wRVU value
Laparoscopic Procedures			
Laparoscopic Sleeve Gastrectomy	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)	43775	20.38
Laparoscopic RYGB (proximal)	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en Y gastroenterostomy (Roux limb 150 cm or less)	43644	29.4
Laparoscopic RYGB (distal)	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	43645	31.53
Laparoscopic Duodenal Switch	Unlisted laparoscopy, stomach	43659	0
Open Procedures			
RYGB (proximal)	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 150 cm) Roux-en-Y gastroenterostomy	43846	27.41
RYGB (distal)	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	43847	30.28
BPD/DS	Gastric restrictive procedure, with partial gastrectomy, pylorus-preserving duodenoileostomy (50 to 100 cm common channel) to limit absorption	43845	33.3
BPD	Gastrectomy, partial, distal; with Roux-en-Y reconstruction	43633	33.14
AGB	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	43843	21.21
Vertical banded gastroplasty	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	43842	21.03
Gastric Band Codes			
Laparoscopic adjustable gastric band and port implantation	Implantation of adjustable gastric band and port, Laparoscopic	43770	18
Lap Revision of gastric band	Revision of adjustable gastric restrictive device component only	43771	20.79
Laparoscopic Removal of gastric band	Removal of adjustable gastric restrictive device component only	43772	15.7
Laparoscopic removal and replacement	Removal and replacement of adjustable gastric restrictive device	43773	20.79
Laparoscopic Removal of gastric band & port	Removal of adjustable gastric band and port	43774	15.76
Open revision of subcutaneous port	Gastric restrictive procedure, open; revision of subcutaneous port only	43886	4.64
Open removal of subcutaneous port	Gastric restrictive procedure, open; removal of subcutaneous port only	43887	4.32
Open removal and replacement of subcutaneous port	Gastric restrictive procedure, open; removal and replacement of subcutaneous port only	43888	6.44
Related Operations			
Laparoscopic Fundoplasty	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)	43280	18.1
Laparoscopic paraesophageal hernia repair	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	43281	26.6
Laparoscopic paraesophageal hernia repair, with mesh	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	43282	30.1
Laparoscopic truncal vagotomy	Laparoscopy, surgical; transection of vagus nerves, truncal	43651	10.13
LINX procedure	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie magnetic band), including cruroplasty when performed	43284	10.13
Cholecystectomy	Laparoscopy, surgical; cholecystectomy	47562	10.47
Laparoscopic lysis of ahesions	Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion)	44180	15.27
Laparoscopic gastrostomy tube	gastrotostomy, without construction of gastric tube (eg Stamm procedure)	43653	8.48
Percutaneous endoscopic gastrostomy	EGD with directed placement of percutanous gastrostomy tube	43246	3.56

	A	B	C	D	E
1	**Revisional Bariatric Procedures**				
2	**Description of procedure**	**Recommended laparoscopic code**	**Comparison open code**	**Descriptor of open code**	**wRVU value of open code**
3	Laparoscopic revision gastrojejunostomy with resection of gastric pouch and proximal Roux limb	43659 (unlisted laparoscopic stomach procedure)	43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy	27.89
4	Laparoscopic reduction of internal hernia or intussusception	44238 (unlisted laparoscopic small bowel procedure)	44050	Reduction of volvulus, intussusception, internal hernia, by laparotomy	15.52
5	Laparoscopic detorsion of volvulus	44238	44050	""	15.52
6	Laparoscopic resection and re-anastomosis of entero-enterostomy	44202, 44203 for each additional segment			23.39, 4.44
7	Laparoscopic closure of internal hernia defect	49329 (unlisted laparoscopic peritoneal or omental procedure)	44850	Suture of mesentery (separate procedure)	12.11
8	Laparoscopic reversal of Roux-en-Y gastric bypass	43659	43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	32.75
9	Laparoscopic removal of silastic/mesh ring with or without subsequent conversion to another bariatric procedure	43659	43848	""	32.75
10	Laparoscopic reversal of vertical banded gastroplasty	43659	43848	""	32.75
11	Laparoscopic biliopancreatic diversion/duodenal switch (traditional)	43659	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)	33.3

	A	B	C	D	E
12	Laparoscopic SADI-S (single anastomosis duodenoileostomy)	43659	43845	""	33.3
13	Laparoscopic conversion of sleeve gastrectomy to duodenal switch	44238, possible 44202+44203 depending on technique	none; consider 43845 with reduced services modifier -52		
14	Laparoscopic gastric access for transgastric ERCP	43659	possibly 43653 (G-tube)	Laparoscopy, surgical; gastrostomy, without construction of gastric tube (eg, Stamm procedure) (separate procedure)	8.48
15	Laparoscopic primary closure of bowel perforation, including marginal or duodenal ulcer	43659 or 44238 - gastric vs duodenal/jejunal	43840	Suture repair of bowel perforation -Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury	22.83
16	Laparoscopic Graham patch (can be used in addition to the primary closure code)	49329, may be able to use 49905	49905	Omental flap, intra-abdominal (List separately in addition to code for primary procedure)	6.54
17	Lap Band adjustment (without use of fluoroscopy)	S2083 (commercial insurance) or 43999 (CMS)	same	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline	1.64
18	Lap Band adjustment (with use of fluoroscopy)	S2083 (commercial insurance) or 43999 (CMS) + 77002 for fluoroscopy			

National Correct Coding Initiative Enacts New PTP Coding Edit For Primary Bariatric Surgery and Paraesophageal Hernia Repair.

On April 1, 2015 The National Correct Coding Initiative (NCCI) published a new set of code pair edits for primary bariatric surgical procedures (CPT 43644/5, 43770, 43775) and Paraesophageal hernia repair with or without mesh (CPT 43281/2). A "code pair edit" eliminates, or limits, the reimbursement of two codes being billing on the same patient on the same day. More information on code pair edits can be found here. (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf).

In 2013, the Insurance committee reported the code pair edit of primary bariatric surgery (CPT 43644, 43770, 43775) reported with fundoplication with hiatal hernia repair (CPT 43280). (http://asmbs.org/articles/insurance-committee-coding-alert-hiatal-hernia-repair-cpt-43280-may-2013) ASMBS has supported the use of CPT 43280 with the reduced work modifier (-52) to report hiatal cruralplasty with primary bariatric surgery. The 2013 code pair edit excludes the reporting of CPT 43280 with primary bariatric surgery codes, without exception, for Medicare beneficiaries. The 2013 edit does not prevent the surgeon from performing the work when indicated. The reasoning for the 2013 edit was that these codes were being routinely reported together for a large percentage of patients and the majority of use was to report a simple anterior figure of eight suture. This additional procedure did not represent a significant amount of additional work to the primary procedure.

The current code pair edit was proposed in the fall of 2014. In this case, the codes are not excluded, but must be reported with an NCCI appropriate modifier and supported with appropriate documentation. ASMBS had the opportunity to comment. Within the request for comment the NCCI specifically mentioned that paraesophageal codes (CPT 43281/2) were being over reported and used to report a "simple figure of eight suture" hiatal hernia repair.

The CPT descriptor for 43281 is below:
"The liver is retracted to allow visualization of the esophageal hiatus. The stomach is gently retracted into the abdomen to assess its degree of tethering in the thorax. The peritoneum overlying the right crus is incised, and the plane along the hernia sac is developed. The dissection is extended anteriorly and laterally to the left crus. The base of the crural confluence is dissected free of adhesions to the sac. The hernia sac is carefully dissected into the mediastinum with caudal traction. The interfaces between the pleura, pericardium, spine, and aorta are developed as the dissection is carried cephalad to the top of the hernia sac. The sac contents are completely reduced back into the abdominal cavity. The hernia sac is then excised taking care to avoid injury to stomach and vagal trunks. An esophageal dilator may be placed transorally. The esophagus is identified and dissected circumferentially and along its mediastinal course in order to reduce tension, allowing the gastroesophageal junction to rest comfortably within the abdominal cavity. Care is taken to identify

and preserve the vagus nerves. The gastro-splenic ligament and the short gastric vessels are divided if necessary. The retro-esophageal window is developed, and the esophagus is retracted caudally. The crural pillars are then approximated with sutures. Anterior reinforcement of the diaphragm is performed with sutures as needed, the tightness of the repair being gauged visually or by the presence of the bougie or other device. Partial or total fundoplasty is then performed with sutures. (Additional sutures may be placed to attach the gastric fundus and/or body to the diaphragm.)"
CPT 43282 – the above repair with the implantation of mesh reinforcement.

Using CPT 43281/2 for a simple anterior figure of eight suture without the appropriate dissection represents a misreporting of the paraesophageal repair code (CPT 43281/2). Based on the 2013 code pair edit, the NCCI feels that this minimal procedure is "incidental" to the primary bariatric procedure.

When the identified hiatal hernia requires the dissection quoted above, the 2015 code pair edit allows reporting CPT 43281/2 with a NCCI appropriate modifier. Per the NCCI manual, "modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. **A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use.** If the Medicare program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI PTP edit if the Medicare restrictions are fulfilled. Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include:

> Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
> Global surgery modifiers: 24, 25, 57, 58, 78, 79
> Other modifiers: 27, 59, 91, XE, XS, XP, XU"

Based on the ASMBS communications with the NCCI, the NCCI recommended modifier for use in the case is Modifier 59.

Per the CPT Manual:

Modifier 59 - Distinct Procedural Service:

"Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. **Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.** However, when another already established modifier is

appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

In Summary, if a full paraesophageal hernia repair that includes complete dissection of the hiatus, dissection of the esophagus, resection of the hernia sac, posterior closure of the crural pillars, fundoplasty and/or gastro/esophagopexy is performed, the procedure can be reported (and paid) when the repair is performed in conjunction primary bariatric surgery. The paraesophageal hernia repair should be reported using CPT 43281/2 with a 59 modifier. However, the paraesophageal hernia repair requires documentation indicating the need for a "**different procedure or surgery, or a different site or organ system"** and appropriate documentation of the repair performed.

Based on past use of NCCI edits by private insurers, surgeons should expect some denials of claims filed with private insurers. The Society feels there is strong basis for appeal based on the current NCCI edits specifically allowing a 59 modifier. Success of these appeals will largely hinge on the precise documentation of the anatomy of the hernia and the conduct of the repair. Familiarization with the CPT patient vignette and the above CPT descriptor is advised.