



ASMBS guidelines/statements

American Society for Metabolic and Bariatric Surgery position statement on describing and coding paraesophageal hernia repair with concurrent bariatric surgery

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The following updated statement is issued by the American Society for Metabolic and Bariatric Surgery (ASMBS) in response to numerous inquiries made to the Society by physicians, society members, billing/coding staff, hospitals, and others, regarding the description and coding of paraesophageal hernia repair with concurrent bariatric surgery. This recommendation is based on current clinical knowledge, expert opinion, and published peer-reviewed scientific evidence available at this time. The statement is not intended as, and should not be construed as, stating or establishing a local, regional, or national standard of care. This is also not intended to replace the collaboration with a certified professional coder in creating and submitting claims for these procedures. This paper is intended to build on the paper previously published by ASMBS in 2015, “National Correct Coding Initiative Enacts New Procedure-to-Procedure Coding Edit for Primary Bariatric Surgery and Paraesophageal Hernia Repair.”

When performing bariatric surgery, it is common to encounter a hiatal or paraesophageal hernia. Management

and surgical repair of hiatal or paraesophageal hernia concomitant with bariatric surgery may impact patient outcomes. Repair of a paraesophageal hernia requires additional operating room time, expertise, and materials, thus it should be reimbursed. In response to perceived code overuse and modifications of standard surgical techniques, reimbursement for hiatal or paraesophageal hernia repairs has been limited by some payors. Due to these limitations, we provide a review of the anatomic definitions and a description of the standard surgical technique for repair of hiatal or paraesophageal hernias, in the context of the Current Procedural Terminology (CPT) coding and billing conventions that are required for payment.

An initial important step is to review the definitions of hiatal and paraesophageal hernias to ensure the operating surgeon and billing staff are consistently coding the same operative findings. Surgeons must then clearly document the type of hernia being treated and essential surgical steps of a billable standard repair for hiatal or paraesophageal hernia. It is outside the scope of this paper to discuss the indications and recommended techniques for repair of other various hernias.

Classically, 4 types of hiatal hernias are described: sliding hiatal hernia (type I), and paraesophageal hernias types II,

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III, and IV. Sliding hiatal hernias (type I) are the most common and occur when the esophago-gastric junction (EGJ) migrates and can slide up and down through the esophageal hiatus. This is not commonly referred to as a paraesophageal hernia. The types II, III, and IV are referred to as variations of paraesophageal hernias. A type II is defined as an EGJ that remains in position, but the gastric fundus herniates to the left lateral side of the hiatus adjacent to the EGJ. These are referred to as “true” paraesophageal hernias. Type II hernias are rare. A type III paraesophageal hernia includes displacement of the EGJ with herniation of the gastric fundus. A type IV paraesophageal hernia is a type of hernia that contains viscera, such as the small or large intestine, the spleen, or the tail of the pancreas in addition to the stomach herniating through the defect. The final determination of the type of paraesophageal hernia will depend on intraoperative findings. Endoscopic findings cannot determine if there is a sliding hernia without a discrete hernia sac or not. It also cannot reliably exclude if there is any additional viscera in the hernia, which would make it a type IV hernia. Paraesophageal hernias may be diagnosed preoperatively, but they may not always appear on preoperative testing. The decision to perform a repair should be based on the surgeon’s clinical judgment intraoperatively. See the [Appendix](#) for sample photos of normal EGJ anatomy and type I, III, and IV hernias.

Secondly, the question arises as to when it is appropriate to repair a paraesophageal hernia at the time of a concurrent bariatric procedure. It has been well established that a sleeve gastrectomy can cause gastroesophageal reflux [1–3]. However, this outcome can be mitigated if a concurrent paraesophageal hernia repair is done at the time of the index procedure [4–7]. In other scenarios, it may be necessary to perform a paraesophageal hernia repair in order to restore anatomy to its proper position so that a bariatric procedure can be performed in the first place [8,9]. In most scenarios, the decision and manner in which to repair a paraesophageal hernia concurrently with a bariatric procedure should be considered based on patient symptoms, anatomic factors including body mass index, size of the hernia, and the procedure being performed. This can impact the long-term outcomes and recurrence rates [10–13]. There are a few retrospective studies demonstrating that paraesophageal and bariatric procedures can be done safely, with similar rates of complications when performed concurrently [8,14,15].

Third, the procedure must be performed and documented to the extent that would justify the code being used. Placing a figure-of-eight suture across a partially dissected esophageal hiatus at the finding of a small anterior dimple of the crura does not include the critical steps delineated in the long descriptor for CPT 43281/2 (below) to be labeled as a paraesophageal hernia repair. In 2014, the Centers for Medicare & Medicaid Services (CMS) sent a letter to the ASMBS specifically stating this. The 3 relevant CPT codes

adjacent to each other are 43280, 43281, and 43282. CPT code 43280 is a laparoscopic gastric fundoplasty without a paraesophageal hernia repair. CPT code 43281 is a paraesophageal hernia repair without mesh, including a fundoplasty if performed. CPT code 43282 is a paraesophageal hernia repair with mesh, including a fundoplasty if performed. The operative note should be written or dictated in such a way to describe all of the key elements involved with the procedure. If elements are not performed or not described properly, then the procedure may not qualify for reimbursement. Referencing the full CPT code description of a procedure can help ensure that proper technical details are included. The full description for CPT code 43281 is as follows:

“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 retroesophageal 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.)” [16]

The National Correct Coding Initiative (NCCI), developed by the Centers for Medicare & Medicaid Services, publishes an edit classification that determines if 2 different CPT codes can be used together. If a complex procedure entails the performance of multiple smaller procedures, those smaller procedures are considered bundled and cannot be billed separately (e.g., the inability to bill for an appendectomy when doing a right hemicolectomy). If a procedure is done that prevents a subsequent procedure from being done, then that will trigger the NCCI edits. In the case of bariatric surgery, a patient undergoing a laparoscopic sleeve gastrectomy (CPT code 43775) cannot have a fundoplication, as

the fundus is resected. For a patient undergoing a laparoscopic Roux-en-Y gastric bypass (CPT code 43644), then CPT code 43280 cannot be billed, because the 43644 code is considered a more extensive procedure. At the time of this writing, the most recent NCCI edits (active 10/1/2022) do not preclude the use of CPT codes 43281 or 43282 with any laparoscopic or open bariatric procedure. However, the NCCI provides specific guidance on how these procedures should be coded for reimbursement. When billing CPT codes 43281/2 in conjunction with primary bariatric procedures, CPT codes 43281/2 should be appended with the –59 distinct procedure modifier and possibly the –52 reduced services modifier. The –59 modifier identifies the paraesophageal hernias as being present in the same anatomic location as the bariatric surgery but requiring a distinct procedure that is uncommon enough and complex enough as to not be included within the services of the primary bariatric surgery. This is distinct from the exclusion of CPT code 43280 from primary bariatric procedures. In addition, the repair is often abbreviated as noted above. For these reasons, repair of sliding hiatal hernias is both common and does not reach the complexity threshold to warrant separate reimbursement. The repair is considered incidental to the primary procedure. This billing convention should be separate from a discussion on whether repair of these small hiatal hernias is clinically indicated and/or beneficial. Discussion of clinical outcomes and indication should occur outside of the bias that reimbursement introduces.

The policies noted above are specific to CMS beneficiaries. As is common, most of these conventions are adopted by private “third-party” insurers as well. However, an individual insurer may modify the above policy or create a new policy that meets the specific practice patterns that occur within the insurer’s coverage area. Some individual insurers or state branches of national insurers have released papers stating that they will not reimburse any concurrent paraesophageal hernia repairs during bariatric surgery. It is the position of the ASMBS that a paraesophageal hernia repair that is indicated and properly documented should be appropriately reimbursed for the additional time and expertise required.

Conclusions

- It is important to understand the definitions of hernias and describe them appropriately.
- Reimbursement for a hernia repair requires performing the expected work and describing it completely.
- If a complete repair is not performed, then the primary bariatric surgery codes can be used with a –22 modifier for increased services performed, or the subsequent paraesophageal code can be used with a –52 modifier for

decreased services performed. Specifically, if an anterior dissection and crural repair is performed, then CPT codes 43281/2 would not be appropriate. Whether it is better to use either of the above modifiers will often come down to individual payor preference as well as coding team preference.

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