CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2641	**Date: January 29, 2013**
	Change Request 8028

Transmittal 2590, dated November 9, 2012, is rescinded and replaced by Transmittal 2641, dated January 29, 2013. Revisions have been made to Business Requirements 8028.2 and 8028.2.1 to include the correct HCPCS Code and responsibility that had been previously omitted. All other information remains the same.

SUBJECT: Bariatric Surgery for the Treatment of Morbid Obesity National Coverage Determination, Addition of Laparoscopic Sleeve Gastrectomy (LSG)

I. SUMMARY OF CHANGES: Effective for claims with dates of service on or after June 27, 2012, Medicare Administrative Contractors acting within their respective jurisdictions may determine coverage of stand-alone laparoscopic sleeve gastrectomy (LSG) for the treatment of co-morbid conditions related to obesity in Medicare beneficiaries only when all of the following conditions a-c are satisfied.

a. The beneficiary has a body-mass index (BMI) ≥ 35 kg/m2,

b. The beneficiary has at least one co-morbidity related to obesity, and,

c. The beneficiary has been previously unsuccessful with medical treatment for obesity.

EFFECTIVE DATE: June 27, 2012
IMPLEMENTATION DATE: February 28, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	32/Table of Contents/Billing Requirements for Special Services
R	32/150.1/General
R	32/150.2/HCPCS Procedure Codes for Bariatric Surgery
R	32/150.3/ICD-9 Procedure Codes for Bariatric Surgery (FIs only)
R	32/150.5/ICD-9 Diagnosis Codes for BMI ≥35
R	32/150.6/Claims Guidance for Payment

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2641	Date: January 29, 2013	Change Request: 8028

Transmittal 2590, dated November 9, 2012, is rescinded and replaced by Transmittal 2641, dated January 29, 2013. Revisions have been made to Business Requirements 8028.2 and 8028.2.1 to include the correct HCPCS Code and responsibility that had been previously omitted. All other information remains the same.

SUBJECT: Bariatric Surgery for the Treatment of Morbid Obesity National Coverage Determination, Addition of Laparoscopic Sleeve Gastrectomy (LSG)

EFFECTIVE DATE: June 27, 2012
IMPLEMENTATION DATE: February 28, 2013

I. GENERAL INFORMATION

A. Background: In 2006, the Centers for Medicare & Medicaid Services (CMS) released a final National Coverage Determination (NCD), Bariatric Surgery for the Treatment of Morbid Obesity (NCD Manual Section 100.1 http://www.cms.gov/manuals/downloads/ncd103c1_Part2.pdf. For Medicare beneficiaries who have a BMI ≥ 35, at least one co-morbidity related to obesity, and who have been previously unsuccessful with medical treatment for obesity, the following procedures were determined to be reasonable and necessary:

- open and laparoscopic Roux-en-Y gastric bypass (RYGBP);
- laparoscopic adjustable gastric banding (LAGB); and
- open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS).

In addition, the NCD stipulates that the above bariatric procedures be covered only when performed at facilities that are: (1) certified by the American College of Surgeons (ACS) as a Level 1 Bariatric Surgery Center or (2) certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (BSCOE) (Program Standards and requirements in effect on February 15, 2006). Due to lack of evidence at the time, the 2006 NCD specifically non-covered open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy (LSG), and open adjustable gastric banding. In 2009, CMS updated the NCD to include type 2 diabetes mellitus as a co-morbidity.

In September 2011, CMS re-opened the NCD to determine whether new and emerging evidence supported inclusion of LSG as a reasonable and necessary bariatric surgery under sections 1862 (a)(1)(A) and/or 1862 (a)(1)(E) of the Act. Open sleeve gastrectomy was not considered and remains non-covered.

B. Policy: Effective for claims with dates on or after June 27, 2012, Medicare Administrative Contractors (MACs) acting within their respective jurisdictions may determine coverage of stand-alone LSG for the treatment of co-morbid conditions related to obesity in Medicare beneficiaries only when all of the following conditions a-c are satisfied.

a. The beneficiary has a body-mass index (BMI) ≥ 35 kg/m2,

b. The beneficiary has at least one co-morbidity related to obesity, and,

c. The beneficiary has been previously unsuccessful with medical treatment for obesity.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8028.1	Effective for claims with dates of service on or after June 27, 2012, MACs acting within their respective jurisdictions may determine coverage of stand-alone LSG, HCPCS code 43775, for the treatment of co-morbid conditions related to obesity in Medicare beneficiaries only when all of the following conditions a-c are satisfied. a. The beneficiary has a body-mass index (BMI) ≥ 35 kg/m2 □, b. The beneficiary has at least one co-morbidity related to obesity, and c. The beneficiary has been previously unsuccessful with medical treatment for obesity. NOTE: This code will appear on the October 2012 Medicare Physcian Fee Schedule update.	X	X		X	X						
8028.2	Contractors shall load 43775 to their HCPCS file with an effective date of June 27, 2012.	X	X		X	X						
8028.2.1	Effective for claims processed for dates of service on and after June 27,2012, through September 30,2012, contractors shall apply contractor pricing to claims containing 43775.	X	X		X	X						
8028.3	Effective for inpatient hospital claims with discharges on or after June 27, 2012, contractors shall allow payment for stand-alone LSG (ICD-9 procedure code 43.82) at their discretion when the following conditions a-c are satisfied: a. The beneficiary has a body-mass index (BMI) ≥ 35 kg/m2, b. The beneficiary has at least one co-morbidity related to obesity, and, c. The beneficiary has been previously unsuccessful with medical treatment for obesity.	X			X							
8028.4	Effective for inpatient hospital discharges on or after	X			X							

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	June 27, 2012, through October 1, 2012, contractors shall override the MCE edit for non-covered procedures when the code below is present on an inpatient claim and when the following conditions a-c are satisfied: a. The beneficiary has a body-mass index (BMI) ≥ 35 kg/m2, b. The beneficiary has at least one co-morbidity related to obesity, and c. The beneficiary has been previously unsuccessful with medical treatment for obesity. ICD-9 Procedure Code 43.82											
8028.5	Contractors shall note that the appropriate ICD-10 code(s) are listed below. Contractors shall track the ICD-10 code/edits (and add the code(s)/edit(s) to their systems when applicable) and ensure that the updated edit is functional as part of the ICD-10 implementation. **NOTE: You will not receive a separate Change Request instructing you to implement updated edits.** **ICD-9-CM Procedure Code 43.82=**0DB64Z3	X			X							
8028.6	Prior to the implementation of this CR, contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention.	X	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility					
		A/B MAC	DME	FI	CAR	RHH	Other

		Part A	Part B	MAC		RIER	I	
8028.7	MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X		X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Patricia Brocato-Simons, 410-786-0261 or Patricia.Brocato-Simons@cms.hhs.gov (Coverage) , Chanelle Jones, 410-786-9668 or Chanelle.jones@cms.hhs.gov , Deirdre O'Connor, 410-786-3263 or deirdre.oconnor@cms.hhs.gov (Coverage) , Wanda Belle, 410-786-7491 or wanda.belle@cms.hhs.gov (Coverage) , Shauntari Cheely, 410-786-1818 or Shauntari.Cheely@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not

obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 32 – Billing Requirements for Special Services

150.1 - General
(Rev. 2641, Issued: 01-29-13, Effective: 06-27-12, Implementation: 02-28-13)

A. Covered Bariatric Surgery Procedures

Effective for services on or after February 21, 2006, Medicare has determined that the following bariatric surgery procedures are reasonable and necessary under certain conditions for the treatment of morbid obesity. The patient must have a body-mass index (BMI) 35, have at least one co-morbidity related to obesity, and have been previously unsuccessful with medical treatment for obesity. This medical information must be documented in the patient's medical record. In addition, the procedure must be performed at an approved facility. A list of approved facilities may be found at http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage.
Open Roux-en-Y gastric bypass (RYGBP).

Laparoscopic Roux-en-Y gastric bypass (RYGBP).

Laparoscopic adjustable gastric banding (LAGB).

Open biliopancreatic diversion with duodenal switch (BPD/DS).

Laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS).

Laparoscopic sleeve gastrectomy. (*Effective June 27, 2012, covered at contractor's discretion.*)

150.2 - HCPCS Procedure Codes for Bariatric Surgery
(Rev. 2641, Issued: 01-29-13, Effective: 06-27-12, Implementation: 02-28-13)

A. Covered HCPCS Procedure Codes

For services on or after February 21, 2006, the following HCPCS procedure codes are covered for bariatric surgery:
43770 - Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components).

43644 - Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less).

43645 - Laparoscopy with gastric bypass and small intestine reconstruction to limit absorption. (Do not report 43645 in conjunction with 49320, 43847.)

43845 - Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoieostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch).

43846 - Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less Roux-en-Y gastroenterostomy. (For greater than 150 cm, use 43847.) (For laparoscopic procedure, use 43644.)

43847 - With small intestine reconstruction to limit absorption.

43775- Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy) (Effective June 27, 2012, covered at contractor's discretion.)

B. Non-Covered HCPCS Procedure Codes

For services on or after February 21, 2006, the following HCPCS procedure codes are non-covered for bariatric surgery:

43842 - Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical banded gastroplasty

NOC code 43999 used to bill for:

Laparoscopic vertical banded gastroplasty

Open sleeve gastrectomy

Laparoscopic sleeve gastrectomy *(for contractor non-covered instances)*

Open adjustable gastric banding

150.3 - ICD-9 Procedure Codes for Bariatric Surgery (FIs only)

(Rev. 2641, Issued: 01-29-13, Effective: 06-27-12, Implementation: 02-28-13)

A. Covered ICD Procedure Codes

For services on or after February 21, 2006, the following ICD-9 procedure codes are covered for bariatric surgery:

44.38 - Laparoscopic gastroenterostomy (laparoscopic Roux-en-Y), or

44.39 - Other gastroenterostomy (open Roux-en-Y), or

44.95 - Laparoscopic gastric restrictive procedure (laparoscopic adjustable gastric band and port insertion), or

To describe either laparoscopic or open BPD with DS, all three following codes must be on the claim:

- 43.89 - Other partial gastrectomy, and
- 45.51 - Isolation of segment of small intestine, and
- 45.91 - Small to small intestinal anastomosis.

NOTE: There is no distinction between open and laparoscopic BPD with DS for the inpatient setting. For either approach, all three codes must appear on the claim to be covered.

Effective June 27, 2012, the following ICD-9 procedure code is covered for bariatric surgery:
43.82 - Laparoscopic sleeve gastrectomy covered at contractor's discretion

150.5 – ICD-9 Diagnosis Codes for BMI ≥35

(Rev. 2641, Issued: 01-29-13, Effective: 06-27-12, Implementation: 02-28-13)

The following ICD-9 diagnosis codes identify BMI 35:
V85.35 - Body Mass Index 35.0-35.9, adult

V85.36 - Body Mass Index 36.0-36.9, adult

V85.37 - Body Mass Index 37.0-37.9, adult

V85.38 - Body Mass Index 38.0-38.9, adult

V85.39 - Body Mass Index 39.0-39.9, adult

V85.41 - Body Mass Index 40.0-44.9, adult
V85.42 - Body Mass Index 45.0-49.9, adult
V85.43 - Body Mass Index 50.0-59.9, adult
V85.44 - Body Mass Index 60.0-69.9, adult

V85.45 - Body Mass Index 70.0 and over, adult
The following ICD-10 diagnosis codes identify BMI 35:
Z6835 - Body Mass Index 35.0-35.9, adult
Z6836 - Body Mass Index 36.0-36.9, adult.
Z6837 - Body Mass Index 37.0-37.9, adult
Z6838 - Body Mass Index 38.0-38.9, adult
Z6839 - Body Mass Index 39.0-39.9, adult
Z6841 - Body Mass Index 40.0-44.9, adult
Z6842 - Body Mass Index 45.0-49.9, adult
Z6843 - Body Mass Index 50.0-59.9, adult
Z6844 - Body Mass Index 60.0-69.9, adult
Z6845 - Body Mass Index 70.0 and over, adult

150.6 - Claims Guidance for Payment

(Rev. 2641, Issued: 01-29-13, Effective: 06-27-12, Implementation: 02-28-13)

A. Covered Bariatric Surgery Procedures

Contractors shall process covered bariatric surgery claims as follows:

1. Identify bariatric surgery claims.

Contractors identify inpatient bariatric surgery claims by the presence of ICD-9-CM diagnosis code 278.01 *(see ICD-10 equivilent in section 150.5)* as the primary diagnosis (for morbid obesity) and one of the covered ICD-9-CM procedure codes listed in §150.3.

Contractors identify practitioner bariatric surgery claims by the presence of ICD-9-CM diagnosis code 278.01 (*ICD-10 equivalent E66.01)* as the primary diagnosis (for morbid obesity) and one of the covered HCPCS procedure codes listed in §150.2.

2. Perform facility certification validation for all bariatric surgery claims on a pre-pay basis.

A list of approved facilities may be found at:
http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage.

3. Review bariatric surgery claims data and determine whether a pre- or post-pay sample of bariatric surgery claims need further review to assure that the beneficiary has a BMI ≥35 (V85.35 - V85.45*) (see ICD-10 equivilents above in section 150.5*), and at least one co-morbidity related to obesity.

The carrier/FI/A/B MAC medical director may define the appropriate method for addressing the obesity-related co-morbid requirement.

NOTE: If ICD-9-CM diagnosis code 278.01 is present, but a covered procedure code (listed in §150.2 or §150.3) is/are not present, the claim is not for bariatric surgery and should be processed under normal procedures.