Medicare Learning Network
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CMS
Information for Medicare Fee-For-Service Health Care Professionals

Physician Quality Reporting Initiative (PQRI) Measures and Specifications

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2007 Physician Quality Reporting Initiative (PQRI) Quality Measures and Specifications are now available. To access both the measures and measure specifications documents, visit the PQRI web page at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html on the CMS website. Once there, go to the Measures/Codes section of the page and scroll down to the Downloads section. Please note that many of the quality codes are new and will be rejected by Medicare claims processing systems prior to the July 1, 2007 HCPCS update.

MLN Matters Number: MM5477
Related Change Request (CR) #: 5477
Related CR Release Date: April 27, 2007
Effective Date: February 21, 2006
Related CR Transmittal #: R1233CP
Implementation Date: May 29, 2007

Clarification of Bariatric Surgery Billing Requirements Issued in CR 5013

Note: MM5013 was revised on January 25, 2013, to add a reference to MLN Matters® article MM8028 (http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8028.pdf), to alert providers that, beginning June 27, 2012, Medicare contractors may determine coverage of stand-alone Laparoscopy Sleeve Gastrectomy for the treatment of comorbid conditions related to obesity when certain conditions are satisfied.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for bariatric surgery related services provided to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5477 which clarifies the claims processing instructions contained in CR 5013 (Transmittals

R931CP and R54NCD; titled Bariatric Surgery for Morbid Obesity).

CAUTION – What You Need to Know

On April 28, 2006, the Centers for Medicare & Medicaid Services (CMS) issued CR 5013 providing coverage for certain bariatric surgical procedures. CMS found that some claims not involving bariatric surgery are being denied in error while some covered bariatric surgery claims are being held rather than paid.

GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these clarifications.

Background

On April 28, 2006, CMS issued CR 5013 (Transmittals R931CP and R54NCD, dated April 28, 2006)) providing coverage for certain bariatric surgical procedures. This national coverage determination (NCD) is contained in section 100.1 of the Medicare NCD Manual.

It came to the attention of the CMS that this NCD is not being implemented uniformly, and CMS found that:

- Some claims not involving bariatric surgery are being denied in error, and
- Some covered bariatric surgery claims are being held rather than paid.

Therefore, CMS is issuing CR5477 to clarify the claims processing instructions contained in CR 5013.

Certain bariatric surgery procedures for treatment of co-morbidities associated with morbid obesity are considered reasonable and necessary under the Social Security Act (Section1862(a)(1)(A)) if the following conditions are satisfied:

1. The Medicare beneficiary:
   - Has a body-mass index (BMI) ≥ 35,
   - Has at least one co-morbidity related to obesity (such as diabetes or hypertension), and
   - Has been previously unsuccessful with medical treatment for obesity.
2. The Procedure is performed in an approved facility listed at http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html on the CMS website.

Note: The NCD itself has not changed and treatments for obesity alone are non-covered.

The following revisions to the *Medicare Claims Processing Manual* (Publication 100-04; Chapter 32) provide guidance for bariatric surgery claims payment:

ICD-9 Diagnosis Codes for BMI ≥35

ICD-9-CM Code	Descriptor
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
V85.4	Body Mass Index 40 and over, adult

Claims must be submitted to carriers or A/B MACs with the ICD-9-CM diagnosis code of 278.01 for morbid obesity and one of the appropriate Healthcare Common Procedure Coding System (HCPCS) codes as follows:

- 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, surgical, gastric restrictive procedure with gastric bypass and small intestine reconstruction to limit absorption.
- 43845 - Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileolieostomy (50 to 100 cm common chanel) 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.
- 43847 - Gastric restrictive procedure with small intestine reconstruction to limit absorption.

Medicare FIs and A/B MACS will accept bariatric surgery claims billed by institutional providers with and ICD-9-CM diagnosis code of 278.01 for morbid obesity and one of the following ICD-9-CM procedure codes:

- 44.38 - Laparoscopic gastroenterostomy; bypass: gastroduodenostomy, gastroenterostomy, gastrogastrostomy; laparoscopic gastrojejunostomy without gastrectomy NEC.
- 44.39 - Other gastroenterostomy; bypass: gastroduodenostomy, gastroenterostomy, gastrogastrostomy; gastrojejunostomy without gastrectomy NOS.
- 44.95 - Laparoscopic gastric restrictive procedure; adjustable gastric band and port insertion.

Note: If ICD-9-CM diagnosis code 278.01 is present, but one of the listed ICD-9-CM procedure codes or HCPCS codes is not present, then the Medicare contractor will determine the claim is not for bariatric surgery and will process the claim accordingly. Also, if one of the ICD-9-cm procedure codes is present without ICD-9-CM diagnosis code 278.01, then the claim is not for bariatric surgery, and the contractor will process the claim accordingly.

Also, to describe either laparoscopic or open biliopancreatic diversion with duodenal switch (BPD/DS), claims must contain all three of the following codes:

- 43.89 - Other; partial gastrectomy with bypass gastrogastrostomy; sleeve resection of stomach.
- 45.51 - Isolation of segment of small intestine; isolation of ileal loop; resection of small intestine for interposition.
- 45.91 - Small-to-small intestinal anastomosis.

Claims submitted to FIs or A/B MACs must contain International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) procedure code reported as specified according to the following conditions:

- The Medicare Contractor will pay the bariatric surgery claim if ICD-9-CM diagnosis code 278.01 (Morbid obesity; severe obesity) is present and all of the following are present:
  - At least one of the specified ICD-9-CM diagnosis codes for BMI ≥35,
  - An appropriate procedure code(s) as listed in the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 32, Sections 150.2 and 150.3,
  - An appropriate obesity-related co-morbid diagnosis code(s), and
  - The procedure was performed in an approved facility.

- The Medicare Contractor will deny the bariatric surgery claim if ICD-9-CM diagnosis code 278.01 is present, but any of the following are not present:
  - At least one of the specified ICD-9-CM diagnosis codes for BMI ≥35,
  - An appropriate procedure code(s) as listed in the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 32, Sections 150.2 and 150.3,
  - An appropriate obesity-related co-morbid diagnosis code(s), and
  - The procedure was performed in an approved facility.

Note: The term, "deny", rather than "reject" is used because beneficiaries and providers are entitled to appeal rights.

- If ICD-9-CM diagnosis code 278.01 is not present, the contractor will adjudicate the non-bariatric surgery claim based on the ICD-9 CM procedure codes listed on the claim.

Non-Covered HCPCS / ICD-9 Procedure Codes

Contractors (carriers and B MACs) will deny bariatric surgery claims when:

- Billed with HCPCS procedure code 43842 (Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty) when used for open vertical banded gastroplasty. Note: This code was included in the April 2006 update of the Medicare Physician Fee Schedule Database and the July update of the Medicare Outpatient Code Editor.
- Billed with HCPCS Not Otherwise Classified (NOC) code 43999 when used for the following noncovered procedures: (When this NOC coded is used, the procedure should be described.)
  - Laparoscopic vertical banded gastroplasty
  - Open sleeve gastrectomy
  - Laparoscopic sleeve gastrectomy
  - Open adjustable gastric banding

Contractors (FIs and A MACs) will reject bariatric surgery claims when:

- Billed with principal ICD-9 CM diagnosis code 278.01 and ICD-9 procedure code 44.68 when used for the following noncovered procedures:
  - Open adjustable gastric banding
  - Laparoscopic vertical banded gastroplasty.

- Billed with principal ICD-9 CM diagnosis code 278.01 and ICD-9 procedure code 44.69 when used for the noncovered procedure, Open vertical banded gastroplasty.
- Billed with principal ICD-9 CM diagnosis code 278.01 and ICD-9 procedure code 43.89 when used for the following noncovered procedures:
  - Open sleeve gastrectomy
  - Laparoscopic sleeve gastrectomy.

Note: Carriers, FIs, or A/B MACs will use Claim Adjustment Reason Code 50 when denying/rejecting claims for noncovered bariatric surgery procedures, reason code 58 when payment is denied due to performing the surgery at an unapproved facility, and reason code 167 when denying the claim because the patient did not meet the conditions for coverage. Appeal rights will be afforded to all parties.

Additional Information

The official instruction, CR5477, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1233CP.pdf on the CMS website. The manual revisions to the Medicare Claims Processing Manual (Pub. 100-04; Chapter 32) included as an attachment to CR5477:

CR 5013, Transmittal R931CP and R54NCD, dated April 28, 2006, may be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R931CP.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R54NCD.pdf) on the CMS website.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found on the CMS website at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.