CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 931 **Date: APRIL 28, 2006**

CHANGE REQUEST 5013

SUBJECT: Billing Requirements for Bariatric Surgery for Treatment of Morbid Obesity

I. SUMMARY OF CHANGES: Effective for services on or after February 21, 2006, Medicare will cover 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) if certain criteria are met and the procedure is performed in an approved facility. In addition, effective for services performed on or after February 21, 2006, Medicare has decided that open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy and open adjustable gastric banding are nationally non-covered for Medicare. The Medicare claims processing manual (Publication 100-04, chapter 32, section 150) has been updated to reflect the new coverage.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: February 21, 2006
IMPLEMENTATION DATE: May 30, 2006 for physician claims billed to the carrier, and October 2, 2006 for hospital claims billed to the FI.

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	32/150/Table of Contents
N	32/150/Billing Requirements for Bariatric Surgery for Morbid Obesity
N	32/150.1/General
N	32/150.2/HCPCS Coding for Bariatric Procedures
N	32/150.3 ICD - 9/Diagnosis Codes for Bariatric Surgery
N	32/150.4/Reasons for Denial and Medicare Summary Notice (MSN), Remittance Advice Codes and Claims Adjustment Reason Code Messages
N	32/150.5/Fiscal Intermediary Billing Requirements
N	32/150.6/ICD - 9 Procedure Codes for Bariatric Procedures
N	32/150.7/Non-Covered ICD - 9 Procedure Code for Bariatric Surgery

N	32/150.8/Advance Beneficiary Notice and HINN Information

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 931	Date: April 28, 2006	Change Request 5013

SUBJECT: Billing Requirements for Bariatric Surgery for Treatment of Morbid Obesity

I. GENERAL INFORMATION

A. Background: National Coverage Determinations Manual (NCD), sections 40.5 and 100.1, are being modified to be consistent with the new policy for bariatric surgery. Bariatric surgery is often an effective treatment for co-morbid conditions in obese individuals who have been unsuccessful with exercise and diet as a means of reducing their co-morbid conditions. There are two main types of gastric surgery for treatment of co-morbid conditions related to morbid obesity: restrictive operations and malabsorptive operations. Other surgeries combine both types of procedures. This specialized surgery is only recommended for individuals with health concerns related to their obesity such as coronary artery disease, diabetes and sleep apnea.

B. Policy: The Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is adequate to conclude that open and laparoscopic Roux-en-Y gastric bypass, laparoscopic adjustable gastric banding, and open and laparoscopic biliopancreatic diversion with duodenal switch, are reasonable and necessary for Medicare beneficiaries who 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 information must be documented in the patient's medical record.

The CMS has determined that covered bariatric surgery procedures are reasonable and necessary only when performed at facilities that are:: (1) certified by the American College of Surgeons as a Level 1 Bariatric Surgery Center (program standards and requirements in effect on February 15, 2006); or (2) certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (program standards and requirements in effect on February 15, 2006).

A list of approved facilities and their approval dates will be listed and maintained on the CMS coverage website at http://www.cms.hhs.gov/coverage, and will be published in the Federal Register.

The evidence is not adequate to conclude that the following bariatric surgery procedures are reasonable and necessary; therefore, the following are non-covered for all Medicare beneficiaries:

1. open vertical banded gastroplasty;
2. laparoscopic vertical banded gastroplasty;
3. open sleeve gastrectomy;
4. laparoscopic sleeve gastrectomy; and
5. open adjustable gastric banding.

The two non-coverage determinations remain unchanged - Gastric Balloon (NCD Manual, section 100.11) and Intestinal Bypass (NCD Manual, section 100.8).

Modification of the current policy on obesity, found in section 40.5, of the NCD Manual, will include a reference to the covered surgical procedures and will merge the obesity policy with the final bariatric surgery policy. The modified obesity policy will read as follows (emphasis added to the new language within the policy):

> Obesity may be caused by medical conditions such as hypothyroidism, Cushing's disease, and hypothalamic lesions or can aggravate a number of cardiac and respiratory diseases as well as diabetes and hypertension. Certain designated surgical services for the treatment of obesity are covered for Medicare beneficiaries who have a BMI $\geq$ 35, have at least one co-morbidity related to obesity and have been previously unsuccessful with the medical treatment of obesity.
>
> Treatments for obesity alone remain non-covered.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5013.1	Contractors shall be advised that procedures performed on or after February 21, 2006 for open and laparoscopic Roux-en-Y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB) and open and laparoscopic biliopancreatic diversion (BPD) with duodenal switch (DS) are covered when performed in facilities that are: (1) Certified by the American College of Surgeons as a Level 1 Bariatric Surgery Center (program standards and requirements in effect on February 15, 2006); or (2) Certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (program standards and requirements in effect on February 15, 2006).	X		X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5013.1.1	Contractors shall allow the following HCPCS as of February 21, 2006: 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.			X						
5013.1.2	Contractors shall accept the following ICD-9-CM Procedure Codes as of February 21, 2006: 44.38-Laproscopic gastroenterostomy (laparoscopic Roux-en-Y).	X				X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	44.39- Other Gastroenterostomy (open Roux-en-Y). 44.95-Laparoscopic gastric restrictive procedure (laparoscipic adjustable gastric band and port insertion). **NOTE:** There is not a distinction between laparoscopic and open BPD with DS for the inpatient setting. All of these codes would apply to the open approach and must be on the claim for the open approach. 43.89 Other partial gastrectomy. 45.51 Isolation of segment of small intestine. 45.91 Small to small intestinal anastomosis.									
5013.2	Contractors shall note that beneficiaries receiving open and laparoscopic RYGBP LAGB and open and laparoscopic BPD/DS must have: (1) A body mass index (BMI) ≥ 35; (2) At least one co-morbidity related to obesity; and (3) Been previously unsuccessful with medical treatment for obesity. **NOTE:** None of the V code diagnoses (which describe BMI ≥ 35) or 278.01 for morbid obesity can be the principle diagnosis on an inpatient Medicare claim.	X		X						
5013.3	Contractors shall accept HCPCS codes 43770, 43644, 43645, 43845, 43846 and 43847 submitted with at least one of the following diagnosis codes: V85.35; V85.36; V85.37; V85.38; V85.39; V85.4; or 278.01.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5013.3.1	In addition to the diagnosis codes listed in BR 5013.3, contractors shall ensure that an obesity related co-morbidity such as a diabetes or hypertension diagnosis must also be present on the claim.			X						
5013.3.2	Contractors shall deny claims for the following HCPCS codes (43770, 43644, 43645, 43845, 43846, and 43847) when submitted without the appropriate diagnosis codes.			X						
5013.3.3	Contractors shall use MSN # 15.4 "The information provided does not support the need for this service or item."	X		X						
5013.3.4	Contractors shall Use Claim Adjustment Reason Code #167 "This (these) diagnosis(es) is (are) not covered"	X		X						
5013.4	Contractors shall accept claims with ICD-9-CM procedure codes 44.38, 44.39, 44.95, 43.89, 45.51, and 45.91, when the following diagnosis codes are reported: V85.35; V85.36; V85.37; V85.38; V85.39; V85.4; and 278.01.	X				X				MCE
5013.4.1	In addition to the diagnosis codes listed in BR 5013.4, contractors shall ensure that an obesity related co-morbidity such as a diabetes or hypertension diagnosis must also be present on the claim. **NOTE:** These ICD-9-CM procedure codes will be paid by FIs, but are subject to post pay review. Any procedure paid in the absence of an obesity related co-morbidity will be denied following post pay review.	X				X				MCE
5013.4.2	Contractors shall deny claims for the following ICD-9-CM procedure codes (44.38, 44.39, 44.95, 43.89, 45.51, and 45.91) when submitted without the appropriate diagnosis codes.	X				X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5013.5	The Medicare Code Editor shall be revised to permit payment for the following procedures in an inpatient setting: 44.38-Laproscopic gastroenterostomy (laparoscopic Roux-en-Y). 44.39- Other Gastroenterostomy (open Roux-en-Y). 44.95-Laparoscopic gastric restrictive procedure (laparoscipic adjustable gastric band and port insertion). **NOTE:** There is not a distinction between laparoscopic and open BPD with DS for the inpatient setting. All of these codes would apply to the open approach and must be on the claim for the open approach: 43.89 Other partial gastrectomy. 45.51 Isolation of segment of small intestine. 45.91 Small to small intestinal anastomosis.	X				X				MCE
5013.6	Contractors shall note that open and laparoscopic RYGBP, LAGB and open and laparoscopic BPD/DS shall be paid for beneficiaries with the covered diagnoses (see BR's 5013.3 and 5013.4) if the facility is certified as specified at: http://www.cms.hhs.gov/coverage.	X		X		X				
5013.6.1	Contractors shall deny claims if the service was performed in an unapproved facility.	X		X						
5013.6.2	Contractors shall use MSN # 16.2 "The service cannot be paid when provided in this location/facility."	X		X						

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5013.6.3	Contractors shall use Claim Adjustment Reason Code 58: "Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service."	X		X						
5013.6.4	Contractors shall advise physicians that the beneficiary is liable for charges if surgery is performed in an unapproved facility. The physician must have the beneficiary sign an Advance Beneficiary Notice (ABN) to avoid this liability.			X						
5013.6.5	Contractors shall advise hospitals, including critical access hospitals (CAHs), that a hospital-issued notice of noncoverage (HINN) must be signed by a beneficiary who wishes to have these services performed on an inpatient basis in an unapproved facility. If the beneficiary does not sign a HINN, the facility is liable for the admission. **NOTE**: HINN model language should be adapted to this situation in the section addressing the description of the care at issue. Other content requirements of a HINN would still apply. Use the HINN letter most appropriate to the overall situation.	X				X				
5013.7	Contractors shall be advised that effective for services on or after February 21, 2006, the following are non-covered for all Medicare beneficiaries: Open vertical banded gastroplasty (HCPCS code 43842); Laparoscopic vertical banded gastroplasty;* Open sleeve gastrectomy;* Laparoscopic sleeve gastrectomy;* and	X		X						

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	Open adjustable gastric banding.* (* Billed with a Not Otherwise Classified {NOC} code)									
5013.7.1	Contractors shall note that the following HCPCS code is non-covered for Medicare effective for services performed on or after February 21, 2006: 43842 - Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical banded gastroplasty. **NOTE**: This code is included in the April 2006 update of the Medicare Physician Fee Schedule Database and the Medicare Outpatient Code Editor July 1, 2006.	X		X		X		X		OCE
5013.7.2	Contractors shall note that the following ICD-9-CM procedure code is non-covered for Medicare effective for services performed on or after February 21, 2006: 44.68 Laparoscopic gastroplasty (vertical banded gastroplasty).	X				X				MCE
5013.7.3	Contractors shall deny claims for services billed with HCPCS 43842, or ICD-9-CM code 44.68 for any of the procedures listed in BR # 5013.7 and 5013.7.2 billed with an NOC code.	X		X		X				
5013.7.4	Contractors shall use MSN # 16.10 “Medicare does not pay for this item or service.” NOTE: If billed with an NOC code, contractors shall use MSN#21.21 “This service was denied because Medicare only covers this service under certain circumstances.”	X		X						
5013.7.5	Contractors shall use Claim Adjustment Reason Code 96 "Non-covered charge(s)."	X		X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5013.8	The contractor shall pay for Bariatric Surgery only when the services are submitted on the following type of bill (TOB): 11X. by hospitals including CAHs.	X				X				
5013.8.1	Contractors shall pay for Bariatric Surgery in Maryland hospitals, on an inpatient basis according to the Maryland State Cost Containment Plan.	X				X				
5013.8.2	Contractors shall pay Indian Health Service (IHS) inpatient hospitals, TOB 11X, under inpatient prospective payment system (IPPS) based on the diagnosis related group (DRG).	X				X				
5013.8.3	Contractors shall pay IHS critical access hospitals, TOB 11X, based on 101% of the facility specific per diem rate.	X				X				
5013.8.4	Contractors shall pay CAHs for inpatient services, TOB 11X, based on 101% of reasonable cost.	X				X				
5013.8.5	Contractors shall pay inpatient hospitals, TOB 11X, under IPPS based on the DRG.	X				X				
5013.9	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						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5013.10	A provider education article related to this instruction will be available at 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 site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: February 21, 2006 **Implementation Date:** May 30, 2006 for physician claims billed to the carrier, and October 2, 2006 for hospital claims billed to the FI. **Pre-Implementation Contact(s):** Kate Tillman 410-786-9252 katherine.tillman@cms.hhs.gov or Eileen Davidson 410-786-6874 eileen.davidson@cms.hhs.gov (coverage); Yvette Cousar (410) 786-2160 yvette.cousar@cms.hhs.gov (carrier claims); Taneka Rivera (410) 786-9502 taneka.rivera@cms.hhs.gov (institutional claims) **Post-Implementation Contact(s):** ROs	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

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

Table of Contents
(Rev.931, 04-28-06)

150 - Billing Requirements for Treatment of Bariatric Surgery for Morbid Obesity

150.1 - General

150.2 - HCPCS Coding for Bariatric Procedures

150.3 - ICD-9 Diagnosis Codes for Bariatric Surgery

150.4 - Reasons for Denial and Medicare Summery Notice (MSN), Remittance Advice Codes and Claims Adjustment Reason Code Messages

150.5 - Fiscal Intermediary Billing Requirements

150.6 - ICD-9 Procedure Codes for Bariatric Procedures

150.7 - Non-Covered ICD-9 Procedure Code for Bariatric Surgery

150.8 - Advance Beneficiary Notice and HINN Information

150 - Billing Requirements for Bariatric Surgery for Treatment of Morbid Obesity

(Rev.931, Issued: 04-28-06, Effective: 02-21-06, Implementation: 05-30-06 Carrier/10-02-06 FI)

150.1 - General

(Rev.931, Issued: 04-28-06, Effective: 02-21-06, Implementation: 05-30-06 Carrier/10-02-06 FI)

Effective for services on or after February 21, 2006, Medicare will cover 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) for beneficiaries who meet the following criteria:

- *have a body-mass index (BMI) ≥ 35,*
- *have at least one co-morbidity related to obesity,*
- *have been previously unsuccessful with medical treatment for obesity, and;*
- *this medical information must be documented in the patient's medical record.*

In addition, CMS has determined that covered bariatric surgery procedures are reasonable and necessary only when performed at an approved facility. A list of approved facilities may be found at http://www.cms.hhs.gov/coverage. Further coverage guidelines can be found in the National Coverage Determination Manual (Publication 100-03), Sections 40.5 and 100.1.

150.2 - HCPCS Coding for Bariatric Procedures

(Rev.931, Issued: 04-28-06, Effective: 02-21-06, Implementation: 05-30-06 Carrier/10-02-06 FI)

For services on or after February 21, 2006, the following HCPCS codes apply for bariatric services:

- *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.*

NOTE: *Effective for services performed on or after February 21, 2006, HCPCS code 43842 is non-covered for Medicare.*

150.3 - ICD-9 Diagnosis Codes for Bariatric Surgery

(Rev.931, Issued: 04-28-06, Effective: 02-21-06, Implementation: 05-30-06 Carrier/10-02-06 FI)

Contractors shall accept claims submitted for bariatric surgery that have the following diagnosis codes with the appropriate HCPCS or ICD-9 procedure code reported.

NOTE: *The claim must contain one of the following diagnoses along with an obesity related co-morbidity.*

- *Body Mass Index (BMI) ≥ 35:*
  V85.35; V85.36; V85.37; V85.38; V85.39; V85.4

- *Morbid Obesity:*
  278.01

NOTE*: None of the V diagnosis codes for BMI ≥35 or 278.01 for morbid obesity can be the principle diagnosis on an inpatient Medicare claim.*

150.4 - Reasons for Denial and Medicare Summary Notice (MSN), Remittance Advice Codes and Claim Adjustment Reason Code Messages

(Rev.931, Issued: 04-28-06, Effective: 02-21-06, Implementation: 05-30-06 Carrier/10-02-06 FI)

- *Contractors shall deny claims for services performed in an unapproved facility. Use the following MSN:*

  16.2 "This service cannot be paid when provided in this location/facility."

  Use the following Claim Adjustment Reason Code:

  58 "Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service."

- *Contractors shall deny claims submitted with HCPCS code 43842 or with an NOC code indicating that any one of the following procedures was performed:*

  - *Laparoscopic vertical banded gastroplasty;*
  - *Open sleeve gastrectomy;*
  - *Laparoscopic sleeve gastrectomy; and*
  - *Open adjustable gastric banding.*

Use the following MSN:

16.10 Medicare does not pay for this item or service.

Use the following Claim Adjustment Code:

96 "Non-covered charge(s)."

- *Contractors shall deny claims submitted for bariartic surgery that do not contain the appropriate diagnosis codes:*

Use the following MSN:

15.4 "The information provided does not support the need for this service or item."

Use the following Claim Adjustment Reason Code:

167 "This (these) diagnosis(es) is (are) not covered"

150.5 - Fiscal Intermediary Billing Requirements

(Rev.931, Issued: 04-28-06, Effective: 02-21-06, Implementation: 05-30-06 Carrier/10-02-06 FI)

The FI will pay for Bariatric surgery only when the services are submitted on the following type of bill (TOB): 11X.

Type of facility and setting determines the basis of payment:

- *For services performed in IHS inpatient hospitals TOB 11X under IPPS payment is based on the DRG.*
- *For services performed in inpatient hospitals, TOB 11X under IPPS payment is based on the DRG.*
- *For services performed in IHS critical access hospitals, TOB 11X, payment is based on 101% facility specific per diem rate.*
- *For services performed in CAH inpatient hospitals, TOB 11X, payment is based on 101% of reasonable cost.*

150.6 - ICD-9 Procedure Codes for Bariatric Procedures

(Rev.931, Issued: 04-28-06, Effective: 02-21-06, Implementation: 05-30-06 Carrier/10-02-06 FI)

For services on or after February 21, 2006, the following ICD-9 procedures apply:

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

44.39- Other Gastroenterostomy (open Roux-en-Y)

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

NOTE: *There is not a distinction between laparoscopic and open BPD with DS for the inpatient setting. The following codes would apply to the open approach.*

43.89 Other partial gastrectomy
45.51 Isolation of segment of small intestine
45.91 Small to small intestinal anastomosis

150.7 - Non-Covered ICD-9 Procedure Code for Bariatric Surgery

(Rev.931, Issued: 04-28-06, Effective: 02-21-06, Implementation: 05-30-06 Carrier/10-02-06 FI)

Effective February 21, 2006, the following ICD-9 procedure code is non-covered for Medicare.

44.68 Laparoscopic gastroplasty (vertical banded gastroplasty)

150.8 - Advance Beneficiary Notice and HINN Information

(Rev.931, Issued: 04-28-06, Effective: 02-21-06, Implementation: 05-30-06 Carrier/10-02-06 FI)

Physicians must be advised that the physician is liable for charges if the surgery is performed in an unapproved facility, unless the beneficiary was informed that he or she would be financially responsible prior to performance for the procedure. The provider must have the beneficiary sign an advance beneficiary notice (ABN) if the bariatric surgery is performed in an unapproved facility. Note that the ABN is the appropriate notice for Part B services.

The HINN model language should be adapted to this situation in the sections addressing: description of the care at issue if the surgery is performed on an inpatient basis, in an unapproved facility, to avoid being liable, the provider must issue a HINN. Other content requirements of HINN still apply. Use the HINN letter most appropriate to the overall situation.