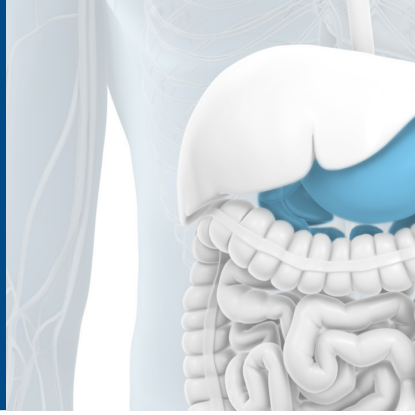
2017 BARIATRIC SURGERY MEDICARE REIMBURSEMENT CODING GUIDE

EFFECTIVE January 1, 2017



CPT Coding and CY 2017 Medicare National Averages for Bariatric Surgery for Physicians, Hospital Outpatient and Ambulatory Surgery Centers

			PHYSICIAN[3]	HOSPITAL OUTPATIENT[4]		ASC[4]
PROCEDURE	**CPT CODE[1]/ HCPCS CODE[2]**	**CODE DESCRIPTION**	**MEDICARE NATL AVG (CF=$35.887) FACILITY SETTING**	**APC AND APC DESCRIPTION**	**MEDICARE NATL AVG**	**MEDICARE NATL AVG**
Gastric Bypass, Laparoscopic	43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	$1,803	Inpatient only, not reimbursed for hospital outpatient or ASC		
	43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	$1,921	Inpatient only, not reimbursed for hospital outpatient or ASC		
Gastric Band, Laparoscopic[5]	43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)	$1,164	5362, Level 2 Laparoscopy	$6,970	N/A for ASC
Gastric Band, Revision and Removal of Band, Laparoscopic[6]	43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	$1,322	Inpatient only, not reimbursed for hospital outpatient or ASC		
	43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	$984	Inpatient only, not reimbursed for hospital outpatient or ASC		
	43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	$1,325	Inpatient only, not reimbursed for hospital outpatient or ASC		
	43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	$997	Inpatient only, not reimbursed for hospital outpatient or ASC		
Gastric Band, Revision and Removal of Port	43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	$375	5055, Level 5 Skin Procedures	$2,505	$1,354
	43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	$338	5055, Level 5 Skin Procedures	$1,428	$772
	43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	$475	5055, Level 5 Skin Procedures	$2,505	$1,354
Adjustment of Band Diameter[7]	S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline	N/A			
Sleeve Gastrectomy, Laparoscopic	43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	$1,147	Inpatient only, not reimbursed for hospital outpatient or ASC		
Vertical-Banded Gastroplasty, Open	43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	not covered by Medicare			

Medtronic

			PHYSICIAN[3]	HOSPITAL OUTPATIENT[4]		ASC[4]
PROCEDURE	CPT CODE[1]/ HCPCS CODE[2]	CODE DESCRIPTION	MEDICARE NATL AVG (CF=$35.887) FACILITY SETTING	APC AND APC DESCRIPTION	MEDICARE NATL AVG	MEDICARE NATL AVG
Other Gastric Restrictive Procedure, Open	43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	$1,321	Inpatient only, not reimbursed for hospital outpatient or ASC		
Biliopancreatic Diversion (without Duodenal Switch)	43632	Gastrectomy, partial, distal; with gastrojejunostomy	$2,114	Inpatient only, not reimbursed for hospital outpatient or ASC		
Biliopancreatic Diversion with Duodenal Switch	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)	$2,041	Inpatient only, not reimbursed for hospital outpatient or ASC		
Gastric Bypass, Open	43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	$1,684	Inpatient only, not reimbursed for hospital outpatient or ASC		
	43847	Gastric restrictive procedure; with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	$1,846	Inpatient only, not reimbursed for hospital outpatient or ASC		
Revision, Gastric Restrictive Procedure[8]	43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	$2,000	Inpatient only, not reimbursed for hospital outpatient or ASC		
Other Revision[9]	43850	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy	$1,679	Inpatient only, not reimbursed for hospital outpatient or ASC		
	43855	Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; with vagotomy	$1,737	Inpatient only, not reimbursed for hospital outpatient or ASC		
	43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy	$1,701	Inpatient only, not reimbursed for hospital outpatient or ASC		
	43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy	$1,762	Inpatient only, not reimbursed for hospital outpatient or ASC		
Robotic Assistance[7]	S2900	Surgical techniques requiring use of robotic surgical system	N/A			

NOTES:

1. CPT copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
2. Centers for Medicare and Medicaid Services. Healthcare Common Procedure Coding System. http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.
3. Centers for Medicare & Medicaid Services. Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017 Final Rule; 81 Fed. Reg. 80170-80562. https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf. Published November 15, 2016. See also the January 2017. See also the January 2017 release of the PFS Relative Value File RVU16A at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html. Final payment to the physician is adjusted by the Geographic Practice Cost Indices (GPCI). Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown.
4. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems Final Rule: 82 Fed. Reg. 24; 24-37 [CMS- 1656-CN]: https://www.federalregister.gov/documents/2017/01/03/2016-31774/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment. Published January 3, 2017. Payment is adjusted by the wage index for each hospital or ASC's specific geographic locality, so payment will vary from the national average Medicare payment levels displayed. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
5. Code 43770 is for placement of both components. Placement of individual components is reported differently by physicians and hospital. Physicians may report 43770 with reduced services modifier -52; codes submitted with modifier -52 generally receive reduced payment after individual review of physician documentation required by the payer. Hospitals may report 43770 with hospital modifier -74, discontinued procedure after administration of anesthesia, which is also appended to indicate partially reduced procedures performed under anesthesia; codes submitted with modifier -74 continue to pay at 100% of the rate (Medicare Claims Processing Manual, chapter 4, 20.6.4).
6. For removal and replacement of both gastric band and subcutaneous port, assign code 43659, unlisted laparoscopy procedure, stomach. For physicians, code 43659 is contractor priced. For hospital outpatient, code 43659 maps to APC 5361, Level 1 Laparoscopy, Medicare national average $4,197. Procedures which use unlisted codes such as 43659 are not permitted by Medicare in ASCs.
7. HCPCS II S-codes cannot be reported to Medicare. They are used only by non-Medicare payers, which cover and price them according to their own requirements.
8. Code 43848 is used for open revision or reversal of gastric restrictive procedures, eg, converting banding to gastric bypass, restapling a dehiscence of a staple restrictive line (see CPT Assistant, May 1998).
9. Although not specifically defined for bariatric procedures, some payers may accept these codes for revisions of gastric bypass procedures.

DIAGNOSIS CODING FOR BARIATRIC SURGERY[1]

ICD-10 went into effect on October 1, 2015. ICD-10-CM diagnosis codes[2] are used by physicians, hospitals, ambulatory surgery centers and other providers to indicate the reason for the encounter.

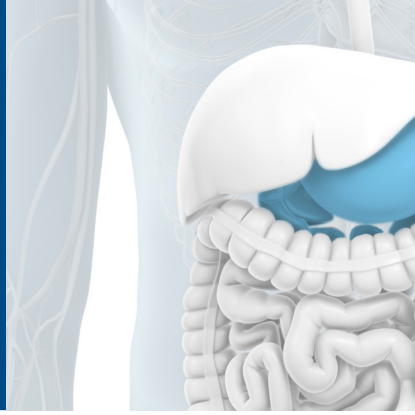
Bariatric procedures are performed for patients who are obese. While the patients typically have associated comorbidities that should also be coded and reported, obesity remains the primary reason for the procedure. Payers may also require that a specific BMI be reported to meet coverage criteria. ICD-10-CM also provides codes specifically for complications of bariatric procedures.

CONDITION	ICD-10-CM DIAGNOSIS CODES	CODE DESCRIPTION
Obesity	E66.01	Morbid (severe) obesity due to excess calories
	E66.09	Other obesity due to excess calories
	E66.8	Other obesity
BMI	Z68.35	Body mass index (BMI) 35.0-35.9, adult
	Z68.36	Body mass index (BMI) 36.0-36.9, adult
	Z68.37	Body mass index (BMI) 37.0-37.9, adult
	Z68.38	Body mass index (BMI) 38.0-38.9, adult
	Z68.39	Body mass index (BMI) 39.0-39.9, adult
	Z68.41	Body mass index (BMI) 40.0-44.9, adult
	Z68.42	Body mass index (BMI) 45.0-49.9, adult
	Z68.43	Body mass index (BMI) 50-59.9 , adult
	Z68.44	Body mass index (BMI) 60.0-69.9, adult
	Z68.45	Body mass index (BMI) 70 or greater, adult
Complications	K95.01	Infection due to gastric band procedure
	K95.09	Other complications of gastric band procedure
	K95.81	Infection due to other bariatric procedure
	K95.89	Other complications of other bariatric procedure

Notes:

1. The codes displayed are representative of diagnoses and procedures that are associated with bariatric surgery. Other diagnosis and procedure codes may also be available. Providers should check with their coding advisors and payers for additional or alternate codes.
2. Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). http:// www.cdc.gov/nchs/icd/icd10cm.htm.

HOSPITAL INPATIENT PROCEDURE CODING FOR BARIATRIC SURGERY[1]



ICD-10 went into effect on October 1, 2015. ICD-10-PCS procedure codes[1] are used by hospitals to report surgeries and procedures performed in the inpatient setting.

All ICD-10-PCS codes have seven digits, each digit representing a specific character associated with procedures. Code assignment in ICD-10-PCS is a process of "constructing" the code by selecting values from a code table for each of the seven standard characters. The first three characters identify the code table that is used to complete the remaining four characters.

Assigning ICD-10-PCS Procedure Codes

CHARACTER	DESCRIPTION
1: Section	For bariatric procedures, the appropriate section is 0-Medical and Surgical.
2: Body System	Because bariatric procedures involve the stomach and intestines, the body system D-Gastrointestinal System.
3: Root Operation	Root operations are assigned according to the objective of the procedure, following standard definitions. Depending on the specific procedure, one of three different root operations are most commonly assigned for bariatric procedures.[4] Note that because the procedure's objective is the defining factor in assigning the root operation, some procedures with different clinical nomenclature may use the same ICD-10-PCS code. • 1-Bypass: Altering the root of passage of the contents of a tubular body part, eg, Roux-en-Y gastric bypass • V-Restriction: Partially closing an orifice or the lumen of a tubular body part, eg, gastric banding • B-Excision: Cutting out or off, without replacement, a portion of a body part, eg, sleeve gastrectomy **Note:** The physician is not expected to document using ICD-10-PCS code descriptions. It is the coder's responsibility to determine what the physician's documentation equates to in terms of ICD-10-PCS definitions and the coder is not required to query the physician in these circumstances.[5]
4: Body Part	On their given code tables, specific body part values are available for stomach, duodenum, and ileum.
5: Approach	Bariatric procedures performed via laparotomy use 0-Open. Procedures performed by laparoscopy use 4-Percutaneous Endoscopic.
6: Device	The device character is not used for surgical instruments that accomplish the procedure but rather for devices that remain in the patient's body after the procedure is completed[6], ie, implanted devices. Gastric banding procedures use C-Extraluminal Device because the band encircles the lumen of the stomach from the outside. For other bariatric procedures, Z-No Device is most common.
7: Qualifier	Qualifiers add further information to the code. For therapeutic procedures, the most common qualifier is Z-No Qualifier. For bypass procedures, the qualifier identifies the body part being bypassed to.[7] For example, re-routing the digestive tract from the stomach directly to the ileum uses qualifier B-Ileum.

Example: Gastric Bypass

SECTION	**0**	Medical And Surgical
BODY SYSTEM	**D**	Gastrointestinal System
OPERATION	**1**	Bypass: Altering the route of passage of the contents of a tubular body part

BODY PART	APPROACH	DEVICE	QUALIFIER
1 Esophagus, Upper **2** Esophagus, Middle **3** Esophagus, Lower **5** Esophagus	**0** Open **4** Percutaneous Endoscopic **8** Via Natural or Artificial Opening Endoscopic	**7** Autologous Tissue Substitute **J** Synthetic Substitute **K** Nonautologous Tissue Substitute **Z** No Device	**4** Cutaneous **6** Stomach **9** Duodenum **A** Jejunum **B** Ileum
1 Esophagus, Upper **2** Esophagus, Middle **3** Esophagus, Lower **5** Esophagus	**3** Percutaneous	**J** Synthetic Substitute	**4** Cutaneous
6 Stomach **9** Duodenum	**0** Open **4** Percutaneous Endoscopic **8** Via Natural or Artificial Opening Endoscopic	**7** Autologous Tissue Substitute **J** Synthetic Substitute **K** Nonautologous Tissue Substitute **Z** No Device	**4** Cutaneous **9** Duodenum **A** Jejunum **B** Ileum **L** Transverse Colon
6 Stomach **9** Duodenum	**3** Percutaneous	**J** Synthetic Substitute	**4** Cutaneous
A Jejunum	**0** Open **4** Percutaneous Endoscopic **8** Via Natural or Artificial Opening Endoscopic	**7** Autologous Tissue Substitute **J** Synthetic Substitute **K** Nonautologous Tissue Substitute **Z** No Device	**4** Cutaneous **A** Jejunum **B** Ileum **H** Cecum **K** Ascending Colon **L** Transverse Colon **M** Descending Colon **N** Sigmoid Colon **P** Rectum **Q** Anus
A Jejunum	**3** Percutaneous	**J** Synthetic Substitute	**4** Cutaneous
B Ileum	**0** Open **4** Percutaneous Endoscopic **8** Via Natural or Artificial Opening Endoscopic	**7** Autologous Tissue Substitute **J** Synthetic Substitute **K** Nonautologous Tissue Substitute **Z** No Device	**4** Cutaneous **B** Ileum **H** Cecum **K** Ascending Colon **L** Transverse Colon **M** Descending Colon **N** Sigmoid Colon **P** Rectum **Q** Anus
B Ileum	**3** Percutaneous	**J** Synthetic Substitute	**4** Cutaneous

- **Gastric bypass from stomach to ileum, performed via laparotomy**

0D160ZB Bypass stomach to ileum, open approach

- **Gastric bypass from stomach to jejunum, performed via laparoscopy**

0D164ZA Bypass stomach to jejunum, percutaneous endoscopic approach

Example: Gastric Banding

SECTION	**0**	Medical And Surgical
BODY SYSTEM	**D**	Gastrointestinal System
OPERATION	**V**	Restriction: Partially closing an orifice or the lumen of a tubular body part

BODY PART	APPROACH	DEVICE	QUALIFIER
1 Esophagus, Upper **2** Esophagus, Middle **3** Esophagus, Lower **4** Esophagogastric Junction **5** Esophagus **6** Stomach **7** Stomach, Pylorus **8** Small Intestine **9** Duodenum **A** Jejunum **B** Ileum **C** Ileocecal Valve **E** Large Intestine **F** Large Intestine, Right **G** Large Intestine, Left **H** Cecum **K** Ascending Colon **L** Transverse Colon **M** Descending Colon **N** Sigmoid Colon **P** Rectum	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**C** Extraluminal Device **D** Intraluminal Device **Z** No Device	**Z** No Qualifier

Example: Sleeve Gastrectomy

SECTION	**0**	Medical And Surgical
BODY SYSTEM	**D**	Gastrointestinal System
OPERATION	**B**	Excision: Cutting out or off, without replacement, a portion of a body part

BODY PART	APPROACH	DEVICE	QUALIFIER
6 Stomach	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**Z** No Device	**3** Vertical **X** Diagnostic **Z** No Qualifier

- **Vertical sleeve gastrectomy, via laparoscopic approach**

0DB64Z3 Excision of stomach, percutaneous endoscopic approach, vertical

Example: Biliopancreatic Diversion

- **Biliopancreatic diversion, open**

0DB60ZZ Excision of stomach, open approach
0D160ZB Bypass stomach to ileum, open approach

- **Pylorus-sparing biliopancreatic diversion with duodenal switch, open**

0DB60ZZ Excision of stomach, open approach
0D190ZB Bypass duodenum to ileum, open approach

Note: For each procedure, multiple codes are assigned to represent the different components of the procedure, eg, partial gastrectomy, re-routing and anastomosis of the small intestine.

Notes:

3. ICD-10-CM: Department of Health and Human Services, Centers for Medicare & Medicaid Services. International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS). http://www.cms.hhs.gov/Medicare/Coding/ICD10/2016-ICD-10-PCS-and-GEMs.html
4. AHA ICD-10-CM and ICD-10-PCS Coding Handbook with Answers 2016, Chapter 20: Disease of Digestive System, Bariatric Surgery and Complications
5. ICD-10-PCS Official Guidelines for Coding and Reporting (Procedure) 2016, A11
6. ICD-10-PCS Official Guidelines for Coding and Reporting (Procedure) 2016, B6.1a
7. ICD-10-PCS Official Guidelines for Coding and Reporting (Procedure) 2016, B3.6a

Additional Procedures

Bariatric patients may requires additional procedures, such as corrections to implanted devices or procedures for operative complications.

Corrections to bariatric devices typically use a specific root operation:[4]

- ***W-Revision:*** Correcting, to the extent possible, a portion of a malfunctioning device or the position of a displaced device, eg, repositioning a gastric band

Procedures for operative complications generally use whatever root operation reflects the objective of the procedure, such as :

- ***D-Dilation:*** Expanding the orifice or the lumen of a tubular body part, eg, ballooning an anastomotic stricture

Example: Revision of Gastric Band

SECTION	**0**	Medical And Surgical
BODY SYSTEM	**D**	Gastrointestinal System
OPERATION	**W**	Revision: Correcting, to the extent possible, a portion of a malfunctioning device or the position of a displaced device

BODY PART	APPROACH	DEVICE	QUALIFIER
6 Stomach	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**0** Drainage Device **2** Monitoring Device **3** Infusion Device **7** Autologous Tissue Substitute **C** Extraluminal Device **D** Intraluminal Device **J** Synthetic Substitute **K** Nonautologous Tissue Substitute **M** Stimulator Lead **U** Feeding Device **Z** No Device	**3** Vertical **X** Diagnostic **Z** No Qualifier

- **Repositioning gastric band via laparoscopy**

0DW64CZ Revision of extraluminal device of stomach, percutaneous endoscopic approach

Note: Root operation Revision is used for correcting a device in some way. It is not used for replacement of a device or for routine band size adjustment by introduction of fluid through the access port. It is also not used for correcting a complication of a prior surgical procedure.

Example: Dilation of Anastomotic Stricture

SECTION	**0**	Medical And Surgical
BODY SYSTEM	**D**	Gastrointestinal System
OPERATION	**7**	Dilation: Expanding an orifice or the lumen of a tubular body part

BODY PART	APPROACH	DEVICE	QUALIFIER
1 Esophagus, Upper **2** Esophagus, Middle **3** Esophagus, Lower **4** Esophagogastric Junction **5** Esophagus **6** Stomach **7** Stomach, Pylorus **8** Small Intestine **9** Duodenum **A** Jejunum **B** Ileum **C** Ileocecal Valve **E** Large Intestine **F** Large Intestine, Right **G** Large Intestine, Left **H** Cecum **K** Ascending Colon **L** Transverse Colon **M** Descending Colon **N** Sigmoid Colon **P** Rectum **Q** Anus	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**D** Intraluminal Device **Z** No Device	**Z** No Qualifier

- **Ballooning of gastrojejunal stricture via EGD, status post Roux-en-Y gastric bypass[8]**

0D768ZZ Dilation of stomach, via natural or artificial opening endoscopic
0D7A8ZZ Dilation of jejunum, via natural or artificial opening endoscopic

Note: Assuming both sides of the anastomosis are dilated, both codes are assigned.

Example: Robotic Assistance

Bariatric procedures are sometimes performed with robotic assistance. ICD-10-PCS provides separate codes for this, which are assigned in addition to the primary bariatric procedure codes. Note that the robotic assistance codes are found in a completely different section from those of the primary procedures.

SECTION	**8**	Other Procedures
BODY SYSTEM	**E**	Physiological Systems and Anatomical Regions
OPERATION	**0**	Other Procedures: Methodologies which attempt to remediate or cure a discorder or disease

BODY PART	APPROACH	DEVICE	QUALIFIER
9 Duodenum **W** Trunk Region	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**C** Robotic Assisted Procedure	**Z** No Qualifier

- **Robotic assistance for laparoscopic gastric bypass**

8E0W4CZ Robotic assisted procedure of trunk region, percutaneous endoscopic approach

Notes:

8. Coding Clinic, 4th Q 2014

HOSPITAL INPATIENT DRGS FOR BARIATRIC SURGERY

Under Medicare's MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 750 diagnosis-related groups, based on the ICD-10 codes assigned to the diagnoses and procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Implanted devices are typically included in the flat payment and are not paid separately. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. MS-DRGs shown are those typically assigned to the following scenarios when the patient is admitted specifically for the procedure.

MS-DRG[9]	MS-DRG TITLE[9,10]	FY 2017 Relative Weight[9]	FY 2017 Geometric Mean Length of Stay[9]	FY 2017 Subject to PACT?[9,11]	FY 2017 Medicare National Average12
PRIMARY BARIATRIC PROCEDURES[13]					
619	OR Procedures for Obesity W MCC	3.0872	3.8	No	$18,410
620	OR Procedures for Obesity W CC	1.7870	2.3	No	$10,657
621	OR Procedures for Obesity W/O CC/MCC	1.5522	1.7	No	$9,256
REVISIONS AND OTHER PROCEDURES[13]					
326	Stomach, Esophageal and Duodenal Procedures W MCC	5.3670	10.9	Yes	$32,006
327	Stomach, Esophageal and Duodenal Procedures W CC	2.5899	5.3	Yes	$15,445
328	Stomach, Esophageal and Duodenal Procedures W/O CC/MCC	1.5357	2.4	Yes	$9.158

Notes:

9. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY2017 Rates Final Rule, 81 Fed. Reg. 80170-80562: https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf. Published November 15, 2016.
10. W MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs W MCC have at least one major secondary complication or comorbidity. Similarly, W CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs W CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs WO CC/MCCs have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions are acquired in the hospital during the stay.
11. Post-Acute Care Transfer (PACT) status refers to selected DRGs in which payment to the hospital may be reduced when the patient is discharged by being transferred out. The DRGs impacted are those marked "Yes" and the patient must be transferred out before the geometric mean length of stay to certain post-acute care providers, including rehabilitation hospitals, long term care hospitals, skilled nursing facilities, or to home under the care of a home health agency. When these conditions are met, the DRG payment is converted to a per diem and payment is made as double the per diem rate for the first day plus the per diem rate for each remaining day up to the full DRG payment.
12. Payment is based on the average standardized operating amount ($5,516.14) plus the capital standard amount ($446.79). Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY2017 Rates; Correction, 81 Fed. Reg. 68947-68963. Tables 1A-1E. https://www.gpo.gov/fdsys/pkg/FR-2016-10-05/pdf/2016-24042.pdf. Published October 5, 2016. The payment rate shown is the standardized amounts for facilities with a wage index greater than one. The average standard amounts shown also assume facilities receive the full quality update. The payment will also be adjusted by the Wage Index for specific geographic locality. Therefore, payment for a specific hospital will vary from the stated Medicare national average payment levels shown. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
13. When the inpatient admission was for the purpose of performing the bariatric procedure, DRGs 619-621 are typically assigned based on a principal diagnosis of obesity. When the patient is admitted for procedures to address complications of bariatric devices or prior bariatric procedures, DRGs 326-328 are typically assigned based on a complication principal diagnosis.

This information is taken from the materials published by the Centers for Medicare and Medicaid Services and the American Medical Association and may be helpful to providers in staying up to date on coding and billing of services. This information cannot guarantee coverage or reimbursement, and Medtronic makes no other representations as to selecting codes for procedures or compliance with any other billing protocols or prerequisites. As with all claims, providers are responsible for exercising their independent clinical judgment in selecting the codes that most accurately reflect the patient's condition and procedures performed for a patient. Providers should refer to current, complete, and authoritative publications such as AMA HCPCS Level II, CPT publications or insurer policies for selecting codes based on the care rendered to an individual patient, and may wish to contact individual carriers, fiscal intermediaries, or other third-party payers as needed.

CPT® is a registered trademark of the American Medical Association. This information is for educational purposes only and is not intended to serve as reimbursement advice. It is the responsibility of the provider to select the codes that most accurately reflect the patient's condition and procedures performed, and to consult with each patient's health plan for appropriate reporting of each procedure. In all cases, services must be medically necessary, actually performed and appropriately documented.

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