Biggest Loser – Bariatric Surgery

Presented by:
Shelly Cronin, CPC, CPMA, CGSC, CGIC, CANPC

Agenda

• Background about morbid obesity and what would qualify a patient for surgery
• Different surgeries and surgical techniques by bariatric surgeons to accomplish maximum safe results for patients
• New procedures/treatments that might be on the horizon
• Proper coding techniques for these surgeries including CPT, ICD9, and HCPCs codes
Bariatric Surgery Beyond Weight Loss

- Surgical treatment for morbid obesity but also for patients with co-morbid metabolic conditions of:
  - Type 2 diabetes
  - Hypertension
  - High cholesterol
  - Sleep apnea
  - Non-alcoholic fatty liver disease
  - Joint disease
  - Asthma
  - Infertility

Migraines
57% resolved

Pseudotumor Cerebri
96% resolved

Dyslipidemia
Hypercholesterolemia
Mildly resolved

Non-Alcoholic Fatty
Liver Disease
83%, improved
steatosis
37% resolution of
inflammation
100% resolution of fibrosis

Metabolic
Syndrome

Type 2
Diabetes Mellitus
63% resolved

Polycystic
Ovarian Syndrome
100% resolution of
ovarian dysfunction

Venous Stasis Disease
95% resolved

Quality of Life
improved in
90% of patients

Depression
95% resolved

Obstructive Sleep Apnea
74-99% resolved

Asthma
62% improved
resolved

Cardiovascular
Disease
82% risk reduction

Hypertension
92-99% resolved

GERD
72-89% resolved

Stress Urinary Incontinence
44-99% resolved

Degenerative Joint Disease
41-76% resolved

Gout
77% resolved

Mortality
89% reduction in
5-year mortality
Definitions

• What is metabolism and a metabolic disease?
  – Metabolism – process which the body converts food to energy at the cellular level
  – Metabolic Disease - any disease that disrupts the conversion of food to energy
  • Most common – Type II diabetes
    – With nearly 21 million people afflicted with type II
    – Another 54 million have pre-diabetes

Definitions

• Metabolic Syndrome - a combination of medical disorders that increase the risk of developing cardiovascular disease and diabetes.
  – also known as metabolic syndrome X, cardiometabolic syndrome, syndrome X, insulin resistance syndrome, Reaven’s syndrome (named for Gerald Reaven), and CHAOS (in Australia).
Morbid Obesity

• When is a person classified as morbidly obese?
  – When a person’s BMI is greater than 40 or they are more than 100 pounds over their ideal body weight
  OR
  – When a person has a BMI of 35 or greater with an existing co-morbidity.

Bariatric Surgery

• Is not a cosmetic procedure
• Proven method of achieving long term weight control for morbidly obese
• Does not involve removal of adipose tissue (fat) by suction or excision.
  – Often performed post operatively once weight stabilizes to remove excessive skin and tissue left due to the dramatic weight loss.
• Involves behavior modification to be successful
Patient Selection

• What determines patient selection?
  – Morbidly obese
  – Well informed
  – Motivated
  – Acceptable operative risks

Bariatric Surgery a History

• Timeline
  – First bariatric surgery was performed in 1954 by A.J. Kremen
    • Procedure linked upper and lower intestines
    • Abandoned due to patients developing complications
Bariatric Surgery a History

• Timeline
  – First Gastric Bypass procedure performed in 1966 by Dr. Edward E. Mason
    • Procedure was called vertical banded gastroplasty
      – Involves creating a pouch from the surgically reduced stomach
    • Procedure failed to gain wide popularity

Bariatric Surgery a History

• Timeline, cont.
  – First Laparoscopic gastric banding performed
    • 1994 by Drs. Wittgrove and Clark
      – Resulted in decrease surgical complications, improve post-operative recovery and shorten hospital stays
  – Future advancements
Biliopancreatic Diversion

- Risks
  - Malnutrition
    - Results in the need the patient to take nutritional supplements for life; above and beyond that of the normal population.
    - 2% of patient’s require reversal to restore normal absorption
  - Gastric staple leakage
  - Stomach ulcers
  - Gallstones
  - Dumping Syndrome
Biliopancreatic Diversion w/Duodenal Switch

• Created to prevent the problem with the malnutrition caused by the original procedure
Biliopancreatic Diversion w/Duodenal Switch

• Open Procedure
  – CPT Code 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)

• Laparoscopic Procedure
  – Unlisted CPT Code 43659
    • Unlisted laparoscopy procedure, stomach

Roux-en-Y Gastric Bypass
Roux-en-Y Gastric Bypass

Variations

• Proximal
  – the Y-intersection is formed near the upper (proximal) end of the small bowel.
    • Benefits - patient experiences very rapid onset of a sense of stomach-fullness, followed by a feeling of growing satiety, or "indifference" to food, shortly after the start of a meal.

• Distal
  – The Y-connection is formed much closer to the lower (distal) end of the small bowel
    • causes reduced absorption (mal-absorption) of food, primarily of fats and starches, but also of various minerals, and the fat-soluble vitamins.

Roux-en-Y Gastric Bypass

• Risks
  – Anastomotic complications
    • Leakage
    • Stricture
    • Ulcer
  – Common Complications
    • Infection
    • Gallstones
    • Vitamin deficiencies
    • Nausea and vomiting
    • Dumping Syndrome
Roux-en-Y Gastric Bypass

• Open Approach
  – CPT Code 43846 - Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy

  – CPT Code 43847 - Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
    • For roux limb greater than 150 cm, report 43847

Roux-en-Y Gastric Bypass

• Laparoscopic Approach
  – CPT Code 43644 - Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)

  – CPT Code 43645 - Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
Sleeve Gastrectomy

- Open Approach
  - CPT code – 43843 - Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
- Laparoscopic Approach
  - CPT Code – 43775 - Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)
Adjustable Gastric Band

• Complications
  – regurgitation of non-acidic swallowed food
  – Ulceration
  – Gastritis
  – Erosion
  – Slippage
  – Malposition of the band
  – Band was not placed on the stomach
  – Problems with the port and/or the tube connecting port and band
  – Internal bleeding
  – Infection
Adjustable Gastric Band

• CPT code 43770
  – Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)
    • Includes subsequent band adjustments (change of the gastric band component diameter by injection/aspiration of fluid through the subcutaneous port component) during the postoperative period
    • If only one component is placed use modifier 52 to report

Revisions

• Open Revisions
  – 43848 - Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device

• Gastric Band Revisions
  – 43771 - Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
  – 43886 - Gastric restrictive procedure, open; revision of subcutaneous port component only
Removals of Adjustable Gastric Band

- 43772 - Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
  - 43773 - removal and replacement of adjustable gastric restrictive device component only
  - 43774 - removal of adjustable gastric restrictive device and subcutaneous port components
- 43887 - Gastric restrictive procedure, open; removal of subcutaneous port component only
  - 43888 - open; removal and replacement of subcutaneous port component only

Body Contouring

- Post bariatric surgery body contouring to remove excess sagging skin of various types:
  - Barchnoplasty
    - removal of excess skin of the upper arm
  - Breast Lift and Augmentation
  - Panniculectomy
    - removal only of the overhanging lower abdominal skin for medical purposes
  - Abdominoplasty
    - removes excessive abdominal skin
  - Lower Body Lift
  - Face and Neck Lift
Expected Weight Loss

- Biliopancreatic diversion - 53 kg
- Roux-en-Y gastric bypass (RYGB) - 41 kg
  - Open - 42 kg
  - Laparoscopic - 38 kg
- Adjustable gastric banding - 35 kg
- Vertical banded gastroplasty - 32 kg

Living with Gastric Bypass

- Physiological Impact
  - Strict dietary requirements
    - Initially clear fluids gradually progressing to a more regular diet high in protein, low in fats and alcohol
  - Fluid Recommendations
    - Minimum of 48-64 fl oz throughout the day to prevent fluid volume depletion and dehydration.
  - Muscle Weakness
Living with Gastric Bypass

• Emotional Impact
  – Depression
    • Due to changes in the role that food plays to emotional well-being
    • Can be linked to the belief that weight loss will “fix” the patient’s problems
  – Development of Disordered Eating

Insurance Coverage

• Most major insurance companies require some combination of the following items for bariatric surgery coverage:
  – Several years of a patient’s medical history
  – Diet and exercise records ranging from three months to a year
  – Recorded histories of obesity ranging from two to several years, accompanied by weight loss attempt documentation
  – Psychological evaluations and clearance
  – Compliance letter from the patient
  – Lab work and tests for cardiac, pulmonary, sleep apnea, other co-morbidities
  – Monitored physician diet plans, physicals, and so forth
**Medicare & Medicaid Coverage**

- Medicare and Medicaid are also increasing their coverage of bariatric procedures, depending on the medical condition of the patient. Medicare currently pays for the following types of bariatric surgery:
  - Gastric bypass
  - Laparoscopic Roux-en-Y gastric bypass
  - Laparoscopic adjustable gastric banding
  - Open and laparoscopic biliopancreatic diversion with duodenal switch

Medicaid coverage for bariatric surgery varies on a state-by-state basis.

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**Appealing for coverage**

- Insurance can deny even with a pre-authorization for coverage
  - Appeal immediately
    - Challenge each reason of the denied coverage
    - Resubmit a letter of medical necessity
Sample Case

Patient A

• Diagnosis: Morbid obesity with BMI of 50, Hypertension
• Procedure: Gastric bypass with Roux-en-Y reconstruction
• Description: Following informed consent and satisfactory general anesthesia was obtained, I performed a gastric bypass by partitioning the stomach and performing a small bowel division and anastomosis to the proximal stomach (Roux-en-Y gastrojejunostomy). I made a midline abdominal incision. The stomach was mobilized and the proximal stomach is divided with a stapling device along the lesser curvature, leaving only a small proximal pouch in continuity with the esophagus. A short limb of the proximal small bowel (150 cm or less) was divided and the distal end of the short intestinal limb is brought up and anastomosed to the proximal gastric pouch. The other end of the divided bowel is connected back into the small bowel distal to the short limb's gastric anastomosis to restore intestinal continuity. The incision is closed. The patient tolerated the procedure well with no immediate complications.

Coding for Sample Case

Patient A

• ICD-9 Codes
  – 278.01 - Morbid obesity
  – 401.9 - Unspecified essential hypertension
  – V85.43 - Body Mass Index 50.0-59.9, adult
• CPT Codes
  – 43846 - Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy

AAPC

Coding for the Business Side of Medicine
Sample Case
Patient B

- Diagnosis: Slipped gastric band
- Procedure: Revision of adjustable gastric band
- Description: Following informed consent and satisfactory general anesthesia was obtained, I performed laparoscopic revision of an adjustable gastric restrictive device. Trocars were placed through the abdomen without complications, the patient's abdomen was then insufflated. The laparoscope and additional trocars were placed through small portal incisions. Saline was removed from the gastric restrictive device and the device was repositioned around the upper stomach. Saline was slowly reintroduced through the existing port to secure the device position. Once the device was in place, the instruments were removed and the incisions were closed. The patient tolerated the procedure well with no immediate complications.

Coding for Sample Case
Patient B

- ICD-9 Codes
  - 996.59 - Mechanical complication due to other implant and internal device, not elsewhere classified
- CPT Codes
  - 43771 - Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
THANK YOU

Resources

• eBariatricSurgery.com - http://www.ebariatricsurgery.com/
• American Society for Metabolic & Bariatric Surgery – http://www.asmbs.org/
• Laparoscopic.md - http://www.laparoscopic.md/bariatrics/bypass.html