2018 Plastics: Panniculectomy/Abdominoplasty/ Lipectomy Reimbursement Fact Sheet

Finding the appropriate ICD-10-PCS Code[1]

STEP 1: Select the code below that best describes the procedure.

Procedure Code	Description (Includes Body Part)	Procedure Code	Description (Includes Body Part)
ØJØ	Alteration / Subcutaneous Tissue and Fascia	ØXØ	Alteration / Anatomical Regions, Upper Extremities
ØWØ	Alteration / Anatomical Regions, General	ØYØ	Alteration / Anatomical Regions, Lower Extremities

STEP 2: Using your coding reference book or software, select the 4 characters that best describe the associated Body Part, Approach, Device and Qualifier in the respective order.

Given the large number of individual procedure codes available for lipectomy procedures, please refer to your coding reference book or coding software to look up the associated Body Part, Approach, Device and Qualifier that best align to the procedure code you identified in Step 1 above.

STEP 3: Combine the characters in the respective order from left to right. This is your ICD-10-PCS Code.

For example, the code for **Alteration of Face, Open Approach (ØWØ2ØZZ)** would be created in the steps below:

Example: **STEP 1:** ØWØ **+** **STEP 2:** Body Part 2 **+** Approach Ø **+** Device Z **+** Qualifier Z **=** **STEP 3:** **ØWØ2ØZZ**

Surgeon CPT, APC & DRG Codes

Surgeon CPT Code[2]	Procedure	Nat Average Medicare Payment Facility[3]	Nat Average Medicare Payment Non-Facility[3]
	Traditional Open Procedure		
1583Ø	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	$1,217	NA
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	943	NA
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	9Ø1	NA
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	918	NA
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	969	NA
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	816	NA
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	745	89Ø
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	659	NA
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	761	9Ø6
+15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen (e.g., abdominoplasty)(includes umbilical transposition and fascial placation)(List separately in addition to code for primary procedure)	Carrier Priced	Carrier Priced
15876	Suction assisted lipectomy; head and neck	Carrier Priced	Carrier Priced
15877	Suction assisted lipectomy; trunk	Carrier Priced	Carrier Priced
15878	Suction assisted lipectomy; upper extremity	Carrier Priced	Carrier Priced
15879	Suction assisted lipectomy; lower extremity	Carrier Priced	Carrier Priced
17999	Unlisted procedure, skin mucous membrane and subcutaneous tissue	Carrier Priced	Carrier Priced

Surgeon CPT, APC & DRG Codes (continued)

OUTPATIENT FACILITY
Hospital Outpatient Department

APC	APC Description	Status	Medicare Payment[4]
5Ø73	Level 3 Excision/ Biopsy/ Incision and Drainage (CPT codes: 15832-15839)	J1	$2,325
5Ø92	Level 2 Breast/Lymphatic Surgery and Related Procedures (CPT code: 1583Ø)	J1	4,812
5Ø55	Level 5 Skin Procedures (CPT codes: 15876, 15877, 15878, 15879)	T	2,71Ø
5Ø54	Level 4 Skin Procedures (CPT codes: 15878)	T	1,568

Ambulatory Surgery Center

CPT Code	Procedure Description	National Average Medicare Payment[5]
1583Ø	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	$2,Ø46
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	1,Ø63
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	1,Ø63
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	1,Ø63
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	1,Ø63
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	1,Ø63
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	1,Ø63
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	1,Ø63
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	1,Ø63
+15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	Packaged
15876	Suction assisted lipectomy; head and neck	1,412
15877	Suction assisted lipectomy; trunk	1,412
15878	Suction assisted lipectomy; upper extremity	817
15879	Suction assisted lipectomy; lower extremity	1,412
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	Carrier priced

INPATIENT FACILITY

DRG	Description*	Average Length of Stay (Days)[6]	National Average DRG Payment[6]
579	Other Skin, Subcutaneous Tissue and Breast Procedures with MCC	8.9	$16,Ø34
58Ø	Other Skin, Subcutaneous Tissue and Breast Procedures with CC	5.Ø	9,376
581	Other Skin subcutaneous Tissue and Breast Procedures without CC/MCC	3.Ø	7,376
619	O.R. Procedures for Obesity with MCC	5.6	18,784
62Ø	O.R. Procedures for Obesity with CC	2.6	11,Ø61
621	O.R. Procedures for Obesity without CC/MCC	1.8	9,538
987*	Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC	1Ø.6	19,5Ø3
988*	Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis with CC	5.9	1Ø,3Ø8
989*	Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis without CC/MCC	2.9	6,663

NOTE: Average MS-DRG payments are at highest potential, since most hospitals do meet the EHR and quality reporting. Other adjustments are hospital-specific.

*CC stands for Complications and Comorbidities while MCC refers to Major Complications and Comorbidities. These are a measure of the severity of an illness indicating additional diagnoses present on a case that may increase the expected resource consumption beyond that of the same case without a CC or MCC under the current Medicare definition. Whether a complication or comorbidity is classified as a CC or MCC is defined by Medicare.

1. Hospital ICD-10-PCS Procedural Coding System, American Medical Association. Copyright © 2017 **2.** All Current Procedural Terminology (CPT) five digit numeric codes, descriptions, numeric modifiers, instructions, guidelines and other material are copyright 2017 American Medical Association. **3.** Medicare Physician Fee Schedule (MPFS), Final Rule [CMS- 1676-F], Federal Register, Vol. 82, No. 219, Wednesday, November 15, 2017; 2018 Physician Conversion Factor (CF) = $35.9996. **4.** Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgery Center Payment Systems Final Rule [CMS-1678-FC], Federal Register, Vol. 87, No. 239, Thursday, December 14, 2017; Final National Average Hospital Outpatient Payment **5.** Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgery Center Payment Systems Final Rule [CMS-1678-FC], Federal Register, Vol. 87, No. 239, Thursday, December 14, 2017; Final National Average ASC Payment. **6.** Medicare Inpatient Prospective Payment System Final Rule [CMS-1677-F], Federal Register (Vol. 82, Issue 155), Monday, August 14, 2017; Final National Average DRG Payment.

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