2021 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)
0J0	Alteration / Subcutaneous Tissue and Fascia	0X0	Alteration / Anatomical Regions, Upper Extremities
0W0	Alteration / Anatomical Regions, General	0Y0	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 1above.

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 (0W020ZZ) would be created in the steps below:

Example: STEP 1: 0W0 + STEP 2: Body Part 2 + Approach 0 + Device Z + Qualifier Z = STEP 3: 0W020ZZ

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		
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	$ 1,201	NA
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	$ 939	NA
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	$ 896	NA
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	$ 912	NA
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	$ 952	NA
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	$ 775	NA
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	$ 733	$ 892
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	$ 661	NA
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	$ 756	$ 917
+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]
5073	Level 3 Excision/ Biopsy/ Incision and Drainage (CPT codes: 15832-15839)	J1	$ 2,370
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures (CPT code: 15830)	J1	$ 5,534
5055	Level 5 Skin Procedures (CPT codes: 15840, 15876, 15877, 15879)	T	$ 3,522
5051	Level 1 Skin Procedures (CPT codes: 17999)	T	$ 180
5054	Level 4 Skin Procedures (CPT codes: 15878)	T	$ 1,715

Ambulatory Surgery Center

CPT Code	Procedure Description	National Average Medicare Payment[5]
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	$ 2,262
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	$ 1,000
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	$ 1,000
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	$ 1,000
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	$ 1,000
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	$ 1,000
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	$ 1,000
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	$ 1,000
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	$ 1,000
+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	$ 1,789
15877	Suction assisted lipectomy; trunk	$ 1,789
15878	Suction assisted lipectomy; upper extremity	$ 871
15879	Suction assisted lipectomy; lower extremity	$ 1,789
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	7.0	$ 18,818
580	Other Skin, Subcutaneous Tissue and Breast Procedures with CC	4.0	$ 10,304
581	Other Skin subcutaneous Tissue and Breast Procedures without CC/MCC	2.3	$ 8,098
619	O.R. Procedures for Obesity with MCC	2.8	$ 19,675
620	O.R. Procedures for Obesity with CC	1.8	$ 11,320
621	O.R. Procedures for Obesity without CC/MCC	1.4	$ 10,261
987*	Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC	7.7	$ 20,967
988*	Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis with CC	4.3	$ 10,803
989*	Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis without CC/MCC	2.3	$ 7,172

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 © 2020 2. All Current Procedural Terminology (CPT) five digit numeric codes, descriptions, numeric modifiers, instructions, guidelines and other material are copyright 2020 American Medical Association. 3. CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B (CMS-1734-F); Addendum B. All MPFS Fee Schedules calculated using CF of $34.8931 effective January 2021 4. CY 2021 Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1736-FC); Addendum B and Final ASC Addenda AA. 5. CY 2021 Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1736-FC); Addendum B and Final ASC Addenda AA. 6. Medicare Inpatient Prospective Payment System Final Rule [CMS-1173-5-F], Federal Register (Vol. 85, Issue 182), Friday, September 18, 2020; Final: National Average DRG Payment.

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