

Medicare Medical Policy

Surgical Treatment for Skin Redundancy

MEDICARE MEDICAL POLICY NUMBER: 259

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INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Service	Medicare Guidelines
Abdominal Lipectomy and Panniculectomy	Local Coverage Determination (LCD): Plastic Surgery (L35163)

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. (*Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021*)

POLICY CROSS REFERENCES

None

The full Company portfolio of Medicare Medical Policies is available online and can be [accessed here](#).

POLICY GUIDELINES

COSMETIC VS. RECONSTRUCTIVE PROCEDURES

Cosmetic Surgery

According to the Medicare Benefit Policy Manual, Chapter 16, §120:

“Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of

the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.”

Therefore, under *Title XVIII of the Social Security Act, Section 1862(a)(1)(P)(10)(4)*, cosmetic procedures or services are excluded from Medicare coverage:

“Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member.”

Reconstructive Surgery

Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. While it is generally performed to improve function, it may also be done to approximate a normal appearance. (*Noridian LCD L35163*)

Medicare Coverage

In order to determine if coverage is available for a procedure, review may be required to determine if the procedure is cosmetic or reconstructive in nature.

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

GENERAL

See the associated local coverage article (LCA) for related coding and billing guidance:

- LCA: Billing and Coding: Plastic Surgery ([A57221](#))

When an abdominoplasty is performed without a panniculectomy, CPT code 17999 may be used (CPT code 15830 is used when performing a panniculectomy alone and codes 15830 and 15847 are used when an abdominoplasty is performed with a panniculectomy).

CODES*

CPT	15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
	15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
	15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
	15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
	15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
	15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
	15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm/hand
	15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
	15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
	15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial placcation) (list separately in addition to code for primary procedure)
	15876	Suction assisted lipectomy; head and neck
	15877	Suction assisted lipectomy; trunk
	15878	Suction assisted lipectomy; upper extremity
	15879	Suction assisted lipectomy; lower extremity
	17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
HCPCS	None	

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, “presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare.” The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. (*Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician’s Fee Schedule, A. Physician’s Services*)
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company [Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website](#) for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

None

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
5/2022	Annual review (converted to new format 2/2023)

3/2023	Annual review, no changes
3/2024	Annual review, no changes
3/2025	Annual review, no changes (10/23/2025: Replaced L37020 with L35163 and updated companion LCA due to Noridian JF consolidation with JE LCD policies)
3/2026	Annual review, no changes