MEDICAL POLICY	Surgical Treatment of Lymphedema (Medicare Only)
Effective Date: 8/1/2022  8/1/2022 Medical Officer Date	Medical Policy Number: 341 Medical Policy Committee Approved Date: 7/2022

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare Only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Suction Assisted Lipectomy (aka, Suction Assisted Protein Lipectomy or SAPL)	Local Coverage Determination (LCD) for *Plastic Surgery* (L37020) **NOTE:** This LCD states, "…when the procedure is utilized to remove a lipoma, it is considered reconstructive surgery. The clinical record must clearly demonstrate medical necessity for the lipoma removal as most such tumors are benign and do not require removal. All other uses are currently considered cosmetic in nature and non-covered." Therefore, suction assisted lipectomy is considered cosmetic for any condition other than lipomas.
Vascularized Lymph Node Transfer (VLNT) *Lymphatic Venous Anastomosis (aka, Lymphaticovenous anastomosis or LVA)*	Company medical policy for Surgical Treatments of Lymphedema (All Lines of Business Except Medicare) I. These procedures are considered **not medically necessary** for Medicare Plan members based on the Company medical policy. *"Investigational"*

Lymphatic-lymphatic bypass *Lymphovenous bypass* *Tissue transfer (e.g., omental)* *Lymphatic physiological microsurgery performed during nodal dissection or breast reconstruction to prevent lymphedema (e.g., LYMPHA or lymphatic microsurgical preventing healing approach)* *Autologous lymph node transplantation;* *Lymphatico-lymphatic bypass;* *Lymphatic-venous-lymphatic plasty*	*<u>services are considered not medically necessary for Medicare Plan members. See Policy Guidelines below.</u>*

POLICY GUIDELINES

<u>Background</u>

Lymphedema surgery can be classified as either excisional or reconstructive.

Excisional surgical procedures for lymphedema involve resection of redundant tissue that may develop in long-standing severe lymphedema and elephantiasis and may include such procedures as debulking and liposuction (also known as lipoplasty, suction-assisted lipectomy, circumferential suction-assisted lipectomy [CSAL], liposuction in lymphedema and lympho-liposuction). Suction Assisted Protein Lipectomy (SAPL) has been used to reduce the ***solid*** component of swelling in chronic lymphedema.

Reconstructive (physiologic) surgical procedures attempt to improve lymphatic drainage with either anastomoses between lymphatic systems (i.e., linking subcutaneous tissues with the deep lymphatics), creating lymphovenous anastomoses or creation of artificial lymph channels. These include such procedures as microsurgical treatment (eg, microsurgical lymphatico-venous anastomosis, lymphatic-capsular-venous anastomosis, lymphovenous bypass), lymph node transfer (LVT; also known as vascularized lymph node transfer or VLNT) and tissue transfers. Microsurgical procedures target the ***fluid*** component that predominates at earlier stages of the disease.

Medicare and Medical Necessity

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.), Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. *(Medicare Managed Care Manual, Ch. 4, §90.5)*

Following an evidence-based assessment of current peer-reviewed medical literature, the Company may consider certain medical services or technologies to be "investigational." The term "investigational" is not limited to devices or technologies which have not received the appropriate governmental regulatory approval (e.g., U.S. Food and Drug Administration [FDA]), but rather may also mean the procedure, device, or technology does not meet all of the Company's technology assessment criteria, as detailed within the Company policy for *Definition: Experimental/Investigational* (MP5).

For Medicare, only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. Thus, services which lack scientific evidence regarding safety and efficacy because they are investigational are "not medically reasonable or necessary" for Medicare Plan members. *(Medicare Claims Processing Manual, Ch. 23, §30 A)*

BILLING GUIDELINES

General

See the associated local coverage article (LCA) for related billing and coding guidance for services addressed by Medicare coverage policy:

- LCA: Billing and Coding: Plastic Surgery (A57222)

CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required	
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 or hand

15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
No Prior Authorization Required Note: Inclusion of a code in this section does not guarantee reimbursement or coverage. The following codes do not require routine review for medical necessity, but they may be subject to audit or benefit denial.	
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
38308	Lymphangiotomy or other operations on lymphatic channels
49904	Omental flap, extra-abdominal (eg, for reconstruction of sternal and chest wall defects)
49905	Omental flap, intra-abdominal (List separately in addition to code for primary procedure)
49906	Free omental flap with microvascular anastomosis
Unlisted Codes All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then it will be **denied as not covered.**	
38589	Unlisted laparoscopy procedure, lymphatic system
38999	Unlisted procedure, hemic or lymphatic system

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to

determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

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.

MEDICAL POLICY CROSS REFERENCES

- Breast Surgery: Reduction Mammoplasty, Reconstructive Surgery and Implant Management (Medicare Only), MP523
- Compression Bandages, Stockings, and Wraps (Medicare Only), MP139
- Compression: Outpatient Pneumatic Devices (Medicare Only), MP138
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (Medicare Only), MP302