

2012 Plastics: Blepharoplasty/Cervicoplasty/ Rhytidectomy Reimbursement Fact Sheet

SURGEON CPT CODE ¹	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT ²
15819	Cervicoplasty	\$762
15820	Blepharoplasty, lower eyelid	570
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	610
15822	Blepharoplasty, upper eyelid	444
15823	Blepharoplasty, upper eyelid; with extensive skin weighting down lid	617
15824	Rhytidectomy; forehead	Carrier Priced
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	Carrier Priced
15826	Rhytidectomy; glabellar frown lines	Carrier Priced
15828	Rhytidectomy; cheek, chin, and neck	Carrier Priced
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	Carrier Priced

NOTE: For bilateral procedures add modifier -50 Bilateral Procedures

OUTPATIENT FACILITY

Hospital Outpatient Department

APC	APC DESCRIPTION	MEDICARE PAYMENT ³
0134	Level II Skin Repair (CPT code: 15819)	\$228
0137	Level V Skin Repair (CPT codes: 15820, 15821, 15822, 15823, 15824, 15825, 15826, 15828, 15829)	1,492

Freestanding Ambulatory Surgery Center

CPT CODE ¹	DESCRIPTION	MEDICARE PAYMENT ⁴
15819	Cervicoplasty	\$131
15820	Blepharoplasty, lower eyelid	861
15821	Blepharoplasty, lower eyelid; with extensive herniated fast pad	861
15822	Blepharoplasty, upper eyelid;	861
15823	Blepharoplasty, upper eyelid; with extensive skin weighting down lid	861
15824	Rhytidectomy; forehead	861
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	861
15826	Rhytidectomy; glabellar frown lines	861
15828	Rhytidectomy; cheek, chin, and neck	861
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	861

INPATIENT FACILITY

ICD-9 CODE ⁵	DESCRIPTION
08.86	Lower eyelid rhytidectomy
08.87	Upper eyelid rhytidectomy
86.82	Facial rhytidectomy
86.89	Other repair and reconstruction of skin and subcutaneous tissue
96.26	Manual reduction of rectal prolapse

NOTE: ICD-9 codes are grouped into Diagnoses Related Groups (DRGs) for Medicare reimbursement using a patient's diagnoses, procedures performed, age, sex and discharge status. One DRG is assigned to each inpatient stay.

INPATIENT FACILITY			
DRG	DESCRIPTION	AVERAGE LENGTH OF STAY (DAYS) ⁶	NATIONAL AVERAGE DRG PAYMENT ⁶
131	Cranial/facial procedures with CC/MCC	5.7	\$12,703
132	Cranial/facial procedures without CC/MCC	2.7	6,743
579	Other skin, subcutaneous tissue and breast procedures with MCC	9.7	15,168
580	Other skin, subcutaneous tissue and breast procedures with CC	5.1	8,335
581	Other skin subcutaneous tissue and breast procedures without CC/MCC	2.4	5,348
619	O.R. Procedures for obesity with MCC	7.6	19,683
620	O.R. Procedures for obesity with CC	3.1	10,352
621	O.R. Procedures for obesity without CC/MCC	1.9	8,354

¹ All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines and other material are copyright 2011 American Medical Association. All Rights Reserved.

² Federal Register, Vol. 76, No. 228, Monday, November 28, 2011/ Rules and Regulations. The 2012 Final Physician Reimbursement Conversion Factor = \$34.0376.

³ Federal Register, Vol. 76, No. 230, Wednesday, November 30, 2011/ Rules and Regulations; Final Hospital Outpatient Payment.

⁴ Federal Register, Vol. 76, No. 230, Wednesday, November 30, 2011/ Rules and Regulations; Final ASC Reimbursement.

⁵ Hospital ICD-9-CM 2010 Volumes 1, 2 & 3, 9th Revision-Clinical Modification, American Medical Association. Copyright © 2011 Saunders, an imprint of Elsevier, Inc.

⁶ Federal Register, Vol. 76, No. 160, Thursday, August 18, 2011/ Rules and Regulations; Final National Average DRG Payment.

Physicians should refer to their provider Carrier Manual for their geographic payments.

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