

2009 Plastics: Blepharoplasty/Cervicoplasty/Rhytidectomy Reimbursement Fact Sheet

SURGEON CPT CODE ¹	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT ²
15819	Cervicoplasty	\$668
15820	Blepharoplasty, lower eyelid;	\$430
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	\$456
15822	Blepharoplasty, upper eyelid;	\$330
15823	Blepharoplasty, upper eyelid; with extensive skin weighting down lid	\$541
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)	\$227
0137	Level V Skin Repair (CPT Codes: 15820, 15821, 15822, 15823, 15824, 15825, 15826, 15828, 15829)	\$1,392

Freestanding Ambulatory Surgery Center

CPT CODE ¹	DESCRIPTION	MEDICARE PAYMENT ⁴
15819	Cervicoplasty	\$139
15820	Blepharoplasty, lower eyelid	\$674
15821	Blepharoplasty, lower eyelid; with extensive herniated fast pad	\$674
15822	Blepharoplasty, upper eyelid;	\$674
15823	Blepharoplasty, upper eyelid; with extensive skin weighting down lid	\$775
15824	Rhytidectomy; forehead	\$674
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	\$674
15826	Rhytidectomy; glabellar frown lines	\$674
15828	Rhytidectomy; cheek, chin, and neck	\$674
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	\$775

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 PAYMENT⁶
131	Cranial/Facial Procedures with CC/MCC	5.8	\$10,797
132	Cranial/Facial Procedures without CC/MCC	2.6	\$5,948
579	Other Skin, Subcutaneous Tissue and Breast Procedures with MCC	10.7	\$15,138
580	Other Skin, Subcutaneous Tissue and Breast Procedures with CC	5.5	\$7,643
581	Other Skin subcutaneous Tissue and Breast Procedures without CC/MCC	2.6	\$4,656
619	O.R. Procedures for Obesity with MCC	8.2	\$17,902
620	O.R. Procedures for Obesity with CC	3.7	\$10,097
621	O.R. Procedures for Obesity without CC/MCC	2.2	\$7,687

1 All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines, and other material are copyright 2008 American Medical Association. All Rights Reserved.

2 Federal Register, Vol. 73, No. 224, Wednesday, November 19, 2008/ Rules and Regulations. The 2009 Physician Reimbursement Conversion Factor = \$36.0666; Federal Register/ page 697726.

3 Federal Register, Vol. 73, No. 223, Tuesday, November 18, 2008/ Rules and Regulations; 2009 Hospital Outpatient Payment.

4 Federal Register, Vol. 73, No. 223, Tuesday, November 18, 2008/ Rules and Regulations; 2009 ASC Reimbursement.

5 Ingenix® 2009 ICD-9-CM for Hospitals-Volumes 1, 2, & 3.

6 Federal Register, Vol. 73, No. 161, August 19, 2008/ Rules and Regulations; 2009 National Average DRG Payment.

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

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