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NOTE: This policy has been revised. The revised policy will be effective January 1, 2027.

Medicare Advantage Policy Manual **Policy ID:** M-SUR220

Surgical Treatments for Lymphedema and Lipedema

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member, including care that may be both medically reasonable and necessary.

The Medicare Advantage medical policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and Centers of Medicare and Medicaid Services (CMS) policies and manuals, along with general CMS rules and regulations. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of a specific CMS coverage determination for a requested service, item or procedure, the health plan may apply CMS regulations, as well as their Medical Policy Manual or other applicable utilization management vendor criteria developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Some services or items may appear to be medically indicated for an individual but they may also be a direct exclusion of Medicare or the member's benefit plan. Medicare and member EOCs exclude from coverage, among other things, services or procedures considered to be investigational (experimental) or cosmetic, as well as services or items considered not medically reasonable and necessary under Title XVIII of the Social Security Act, §1862(a)(1)(A). In some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services. Members, their appointed representative, or a treating provider can request coverage of a service or item by submitting a pre-service organization determination prior to services being rendered.

DESCRIPTION

Lymphedema is an accumulation of fluid due to disruption of lymphatic drainage. Lymphedema caused by congenital or inherited abnormalities in the lymphatic system is known as primary lymphedema, while lymphedema caused by acquired damage to the lymphatic system is known as secondary lymphedema. One of the most common causes of secondary lymphedema is breast cancer treatment. A variety of non-surgical therapies may be used for treating lymphedema, including conservative therapy, compression therapy and/or bandages, manual lymphatic drainage, complete or complex decongestive therapy, and pneumatic compression pumps.

Lipedema is a separate condition where increased fat tissue accumulates under the skin, causing non-pitting swelling. While lipedema is typically seen in the lower extremities, it can be seen in the upper extremities as well. The cause for lipedema is unknown. Management of lipedema is distinct from lymphedema. Conservative treatment generally used is complete or

complex decongestive therapy (CDT), which combines manual lymph drainage, compression therapy, and physical mobilization.

Proposed surgical treatments of both lymphedema and lipedema include reductive techniques such as liposuction, as well as the following procedures:

- Suction Assisted (Suction-Assisted) Protein Lipectomy (SAPL);
- Lymphatic Venous Anastomosis (aka, Lymphaticovenous anastomosis or LVA);
- Vascularized Lymph Node Transfer (VLNT);
- Autologous lymph node transplantation;
- Lymphatico-lymphatic bypass;
- Lymphatic-venous-lymphatic plasty;
- Lymphovenous bypass

MEDICARE ADVANTAGE POLICY CRITERIA

Note: This medical policy addresses only ***surgical*** treatment of lymphedema and lipedema. ***Non-surgical*** treatments, such as compression or bandage therapy, manual lymphatic drainage, complete decongestive therapy, and pneumatic compression pumps, are not addressed in this Medicare Advantage medical policy. See Cross References below and the Medicare Advantage pre-authorization web page for other applicable policies or review requirements.

CMS Coverage Manuals

None

National Coverage Determinations (NCDs)

For Medicare Coverage Determinations and Articles, see the Medicare Coverage Database

None

Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles

For Medicare Coverage Determinations and Articles, see the Medicare Coverage Database

None

While the Noridian LCD for *Plastic Surgery* (L35163) does address suction-assisted lipectomy (reported with CPT codes 15876-15879) for lipomas, this is considered a different procedure from suction-assisted ***protein*** lipectomy (SAPL). Therefore, the health plan has determined this LCD does not apply to SAPL and similar procedures.

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Medicare coverage guidance is not available for suction assisted (suction-assisted) protein lipectomy (SAPL), lymphatic venous anastomosis (aka, Lymphaticovenous anastomosis or LVA), vascularized lymph node transfer (VLNT), autologous lymph node transplantation, lymphatico-lymphatic bypass, lymphatic-venous-lymphatic plasty, or lymphovenous bypass. Therefore, the health plan's medical policy is applicable.

Surgical Treatments for Lymphedema and Lipedema, Surgery, Policy No. 220 *(see "NOTE" below)*

NOTE: If a procedure or device lacks scientific evidence regarding safety and efficacy because it is investigational or experimental, the service is noncovered as not reasonable and necessary to treat illness or injury. (*Medicare IOM Pub. No. 100-04, Ch. 23, §30 A*). According to Title XVIII of the Social Security Act, §1862(a)(1)(A), only medically reasonable and necessary services are covered by Medicare. In the absence of a NCD, LCD, or other coverage guideline, CMS guidelines allow a Medicare Advantage Organization (MAO) to make coverage determinations, applying an ***objective, evidence-based process, based on authoritative evidence***. (*Medicare IOM Pub. No. 100-16, Ch. 4, §90.5*). The Medicare Advantage Medical Policy - Medicine Policy No. M-149 - provides further details regarding the plan's evidence-assessment process (see Cross References).

POLICY GUIDELINES

The fact a new service or procedure has been issued a CPT/HCPCS code or may have Food and Drug Administration (FDA) approval for a specific indication does not, in itself, make the procedure medically reasonable and necessary. The FDA determines safety and effectiveness of a device or drug, but does not establish medical necessity or Medicare coverage. While Medicare may adopt FDA determinations regarding safety and effectiveness, Medicare or Medicare contractors evaluate whether or not the drug or device is reasonable and necessary for the Medicare population under §1862(a)(1)(A).

CROSS REFERENCES

1. Pneumatic Compression Devices, Durable Medical Equipment (DME), Policy No. M-78
2. Investigational (Experimental) Services, New and Emerging Medical Technologies and Procedures, and Other Non-Covered Services, Medicine, Policy No. M-149
3. Gender Affirming Interventions for Gender Dysphoria, Medicine, Policy No. M-153
4. Cosmetic and Reconstructive Procedures, Surgery, Policy No. M-12

REFERENCES

1. Noridian LCA, *Lymphedema Decongestive Treatment* (A52959) [Last Cited 07/21/2024] *(This reference can be found on the Medicare Coverage Database website)*
2. Noridian LCA, *High Compression Bandage System Clarification* (A52768) [Last Cited 07/21/2024] *(This reference can be found on the Medicare Coverage Database website)*

CODING

NOTES:

- Codes requiring prior authorization are listed on the "Medicare Pre-authorization List" web page. Codes not listed on the pre-authorization website do not require prior approval, but may not be considered medically necessary for any indication. There may be codes related to lymphedema or lipedema treatments not included in this medical policy, but providers are always expected to follow Medicare's medical necessity requirements when rendering treatment to beneficiaries
- Reporting CPT code 38999 for the treatment of lipedema is **not** appropriate as lipedema is not a disease of the lymphatic system.

Codes	Number	Description
CPT	1019T	Lymphovenous bypass, including robotic assistance, when performed, per extremity

Codes	Number	Description
	1081T	Microvascular anastomosis between a lymph node and a vein, including robot assistance, when performed; initial anastomosis
	1082T	Microvascular anastomosis between a lymph node and a vein, including robot assistance, when performed; each additional anastomosis (List separately in addition to code for primary procedure)
	15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
	15833	; leg
	15834	; hip
	15835	; buttock
	15836	; arm
	15837	; forearm or hand
	15838	; submental fat pad
	15839	; other area
	15876	Suction assisted lipectomy; head and neck
	15877	; trunk
	15878	; upper extremity
	15879	; lower extremity
	38999	Unlisted procedure, hemic or lymphatic system
HCPCS	None	