

Cosmetic and Reconstructive Procedures

Policy Number: MCS022.09

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 [Instructions for Use](#)

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Related Medicare Advantage Policy Guidelines

- [Cosmetic and Reconstructive Services and Procedures](#)
- [Gender Dysphoria and Gender Reassignment Surgery \(NCD 140.9\)](#)

Coverage Guidelines

Cosmetic surgery, reconstructive surgery, or breast reconstruction post mastectomy is covered when Medicare criteria are met.

Note: The guidelines in this Coverage Summary are for specific procedures only. For procedures not addressed in this Coverage Summary, refer to the [Medicare Coverage Database](#) to search for applicable coverage policies (National Coverage Determination, Local Coverage Determinations and Local Coverage Articles).
(Accessed December 6, 2023)

General Coverage Guidelines

Reconstructive surgery is surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, tumors, or disease. Reconstructive surgery is generally performed to improve function, but may also be done to approximate normal appearance. Refer to multiple LCDs for Cosmetic and Reconstructive Surgery at <https://www.cms.gov/medicare-coverage-database/new-search/search.aspx>.

Cosmetic Surgery is surgery performed to reshape normal structures of the body to improve the patient's appearance and self-esteem. Refer to multiple LCDs for Cosmetic and Reconstructive Surgery at <https://www.cms.gov/medicare-coverage-database/new-search/search.aspx>.

Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery is only covered 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. Refer to the [Medicare Benefit Policy Manual, Chapter 16, §120 – Cosmetic Surgery](#).
(Accessed December 6, 2023)

Breast Reconstruction Following Mastectomy

Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered a relatively safe and effective non-cosmetic procedure. Accordingly, program payment may be made for breast reconstruction surgery following removal of a breast for any medical reason. Refer to the [National Coverage Determination \(NCD\) for Breast Reconstruction Following Mastectomy \(140.2\)](#).

When a member elects breast reconstruction following a medically necessary mastectomy or lumpectomy, coverage in accordance with Medicare guidelines is to be provided as determined through consultation between the attending physician and the member. Refer to the [Women's Health and Cancer Rights Act \(WHCRA\)](#).

Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the table for [Breast Implant and Tissue Expansion](#).

Covered services include, but are not limited to:

- External breast prosthesis and bras; refer to the Coverage Summary titled [Durable Medical Equipment \(DME\), Prosthetics, Corrective Appliances/Orthotics \(Non-Foot Orthotics\), Nutritional Therapy, and Medical Supplies Grid](#).
- Breast Implant and Tissue Expansion (CPT codes 19357).
 - Medicare does not have an NCD for breast implant and tissue expansion. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the table for [Breast Implant and Tissue Expansion](#).
 - For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled [Breast Reconstruction](#) for coverage guideline.
Note: After checking the [Breast Implant and Tissue Expansion](#) table and searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
- Pneumatic compression devices are covered for the treatment of physical complications resulting from the mastectomy or lumpectomy, including lymphedema. Refer to the Coverage Summary titled [Durable Medical Equipment \(DME\), Prosthetics, Corrective Appliances/Orthotics \(Non-Foot Orthotics\), Nutritional Therapy, and Medical Supplies Grid](#).
- Myocutaneous flaps (CPT codes 19361, 19364, 19367, 19368, 19369).
 - Medicare does not have an NCD for myocutaneous flaps. Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the table for [Myocutaneous Flaps](#).
 - For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled [Breast Reconstruction](#) for coverage guidelines.
Note: After checking the [Myocutaneous Flaps](#) table and searching the [Medicare Coverage Database](#), if no state LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Reconstructive services are not covered for members who have not had a medically necessary mastectomy or lumpectomy and who are requesting surgery only for the purpose of creating symmetrical breasts or other cosmetic purpose.

Program payment may not be made for breast reconstruction for cosmetic reasons. (Cosmetic surgery is excluded from coverage under §1862(a)(10) of the Act). Refer to the [NCD for Breast Reconstruction Following Mastectomy \(140.2\)](#).

Note: On July 24, 2019, the Food and Drug Administration (FDA) issued a safety communication related to the voluntary recall of certain Allergan BIOCELL textured breast implants and tissue expanders. For specific information, refer to the following FDA communication at: [Allergan Voluntarily Recalls BIOCELL® Textured Breast Implants and Tissue Expanders \(FDA\)](#).

For guidelines on services related to and required as a result of services which are not covered under Medicare. Refer to the [Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage, §180 – Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare](#).

(Accessed December 6, 2023)

Breast Reduction Surgery (Reductive Mammoplasty) (CPT Code 19318)

Medicare does not have a National Coverage Determination (NCD) for breast reduction (reductive mammoplasty). Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist **for all states/territories** and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Breast Reduction \(Reductive Mammoplasty\)](#).

Blepharoplasty

Refer to the Coverage Summary titled [Blepharoplasty and Related Procedures](#).

Ear Graft (CPT Code 21235)

Medicare does not have a National Coverage Determination (NCD) for ear graft. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled [Cosmetic and Reconstructive Procedures](#).

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

(Accessed December 6, 2023)

Treatment of Actinic Keratosis

Destruction of actinic keratosis without restrictions based on lesion or patient characteristics is covered. Refer to the [NCD for Treatment of Actinic Keratosis \(250.4\)](#). (Accessed December 6, 2023)

Panniculectomy/Abdominal Lipectomy (CPT Codes 15830, 15847, 15832, 15833, 15834, 15835, 15836, 15837, 15838, and 15839)

Medicare does not have a National Coverage Determination (NCD) for panniculectomy/lipectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Panniculectomy/Abdominal Lipectomy](#).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled [Panniculectomy and Body Contouring Procedures](#).

Note: After checking the [Panniculectomy/Abdominal Lipectomy](#) table and searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

(Accessed December 6, 2023)

Suction-Assisted Lipectomy (CPT Codes 15876, 15877, 15878, and 15879)

Medicare does not have a National Coverage Determination (NCD) for suction assisted lipectomy. Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Suction-Assisted Lipectomy](#).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled [Panniculectomy and Body Contouring Procedures](#).

Note: After checking the [Suction-Assisted Lipectomy](#) table and searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

(Accessed December 6, 2023)

Mastopexy (CPT Code 19316)

Medicare does not have a National Coverage Determination (NCD) for mastopexy. Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist **for all states/territories** and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Mastopexy](#).

Gynecomastia Treatment (CPT Code 19300)

Medicare does not have a National Coverage Determination (NCD) for gynecomastia. Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for [Gynecomastia Surgery](#).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled [Gynecomastia Surgery](#).

Note: After checking the [Gynecomastia Surgery](#) table and searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed December 6, 2023)

Myocutaneous Flaps for the Head, Neck, Trunk, and Extremities (CPT Codes 15731, 15733, 15734, 15736, 15738, and 15756)

Medicare does not have an NCD for myocutaneous flaps. Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled [Cosmetic and Reconstructive Procedures](#).

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed December 6, 2023)

Toe Polydactyly Reconstruction (CPT Code 28344)

Medicare does not have an NCD for toe polydactyly reconstruction. Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled [Cosmetic and Reconstructive Procedures](#).

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed December 6, 2023)

Pectus Deformity Repair (CPT Codes 21740, 21742, and 21743)

Medicare does not have a National Coverage Determination (NCD) for pectus deformity repair. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled [Pectus Deformity Repair](#).

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed December 6, 2023)

Septoplasty, Rhinoplasty, Vestibular Stenosis Repair, and Balloon Sinuplasty

Refer to the Coverage Summary titled [Nasal and Sinus Procedures](#).

Gender Dysphoria Treatment

There is an [NCD for Gender Dysphoria and Gender Reassignment Surgery \(140.9\)](#) which states that CMS determined that no NCD is appropriate at this time for gender reassignment surgery for Medicare beneficiaries with gender dysphoria and coverage determination will continue to be made by the local Medicare Administrative Contractors (MACs) on a case-by-case basis.

Local Coverage Determination (LCD)/Local Coverage Articles (LCAs) exist and compliance with this policy is required where applicable. For specific LCDs/LCAs, refer to the table for [Gender Dysphoria Treatment](#).

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled [Gender Dysphoria Treatment \(for Commercial Only\)](#).

Note: After checking the [Gender Dysphoria Treatment](#) table and searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed December 6, 2023)

For other related cosmetic procedures, refer to the applicable guideline(s) on this Coverage Summary; refer to the [Index](#) above for the list of these guidelines.

Note: Cross sex hormone therapy may be covered as part of gender dysphoria treatment; Part B vs Part D coverage rules also apply. For Part B vs Part D medication coverage guideline, refer to the Coverage Summary titled [Medications/Drugs \(Outpatient/Part B\)](#).

Light and Laser Therapy for Rosacea and Rhinophyma

Medicare does not have a National Coverage Determination (NCD) for light and laser therapy for rosacea and rhinophyma. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled [Light and Laser Therapy](#).

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed December 6, 2023)

Insertion of Tissue Expander for Other Than Breast (CPT Code 11960)

Medicare does not have an NCD for insertion tissue expander for other than breast. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled [Cosmetic and Reconstructive Procedures](#).

Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed December 6, 2023)

Supporting Information

| Breast Implant and Tissue Expansion (CPT codes 19340, 19342 and 19357) Myocutaneous Flaps (CPT codes 19361, 19364, 19367, 19368 and 19369) | | | | |
|---|---|------------------------|--|--|
| Accessed December 6, 2023 | | | | |
| LCD/LCA ID | LCD/LCA Title | Contractor Type | Contractor Name | Applicable States/Territories |
| L38914 (A58573) | Cosmetic and Reconstructive Surgery | Part A and B MAC | First Coast Service Options, Inc. | FL, PR, VI |
| L35163 (A57221) | Plastic Surgery | Part A and B MAC | Noridian Healthcare Solutions, LLC | AS, CA, GU, HI, MP, NV |
| L37020 (A57222) | Plastic Surgery | Part A and B MAC | Noridian Healthcare Solutions, LLC | AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY |
| L35090 (A56687) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Novitas Solutions, Inc. | AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX |
| L33428 (A56658) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Palmetto GBA | AL, GA, NC, SC, TN, VA, WV, |
| L39051 (A58774) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Wisconsin Physicians Service Insurance Corp. | IA, IN, KS, MI, MO, NE |

Breast Implant and Tissue Expansion (CPT codes 19340, 19342 and 19357)**Myocutaneous Flaps (CPT codes 19361, 19364, 19367, 19368 and 19369)**

Accessed December 6, 2023

| LCD/LCA ID | LCD/LCA Title | Contractor Type | Contractor Name | Applicable States/Territories |
|------------------------------------|---------------|-----------------|-----------------|-------------------------------|
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Breast Reduction (Reductive Mammoplasty)

Accessed December 6, 2023

| LCD/LCA ID | LCD/LCA Title | Contractor Type | Contractor Name | Applicable States/Territories |
|------------------------------------|---|------------------|--|--|
| L39506 (A59299) | Cosmetic and Reconstructive Surgery | Part A and B MAC | CGS Administrators, LLC | KY, OH |
| L38914 (A58573) | Cosmetic and Reconstructive Surgery | Part A and B MAC | First Coast Service Options, Inc. | FL, PR, VI |
| L35001 (A56837) | Reduction Mammoplasty | Part A and B MAC | National Government Services, Inc. | CT, IL, MA, ME, MN, NH, NY, RI, VT, WI |
| L35163 (A57221) | Plastic Surgery | Part A and B MAC | Noridian Healthcare Solutions, LLC | CA, AS, GU, HI, MP, NV |
| L37020 (A57222) | Plastic Surgery | Part A and B MAC | Noridian Healthcare Solutions, LLC | AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY |
| L35090 (A56587) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Novitas Solutions, Inc. | AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX |
| L33428 (A56658) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Palmetto GBA | AL, GA, NC, SC, TN, VA, WV |
| L39051 (A58774) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Wisconsin Physicians Service Insurance Corporation | IA, IN, KS, MI, MO, NE |
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Panniculectomy/Abdominal Lipectomy

Accessed December 6, 2023

| LCD/LCA ID | LCD/LCA Title | Contractor Type | Contractor Name | Applicable States/Territories |
|------------------------------------|---|------------------|--|--|
| L39506 (A59299) | Cosmetic and Reconstructive Surgery | Part A and B MAC | CGS Administrators, LLC | KY, OH |
| L38914 (A58573) | Cosmetic and Reconstructive Surgery | Part A and B MAC | First Coast Service Options, Inc. | FL, PR, VI |
| L35163 (A57221) | Plastic Surgery | Part A and B MAC | Noridian Healthcare Solutions, LLC | CA, AS, GU, HI, MP, NV |
| L37020 (A57222) | Plastic Surgery | Part A and B MAC | Noridian Healthcare Solutions, LLC | AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY |
| L35090 (A56587) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Novitas Solutions, Inc. | AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX |
| L33428 (A56658) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Palmetto GBA | AL, GA, NC, SC, TN, VA, WV |
| L39051 (A58774) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Wisconsin Physicians Service Insurance Corporation | IA, IN, KS, MI, MO, NE |
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| Suction-Assisted Lipectomy | | | | |
|------------------------------------|---|------------------|--|--|
| Accessed December 6, 2023 | | | | |
| LCD/LCA ID | LCD/LCA Title | Contractor Type | Contractor Name | Applicable States/Territories |
| L35163 (A57221) | Plastic Surgery | Part A and B MAC | Noridian Healthcare Solutions, LLC | CA, AS, GU, HI, MP, NV |
| L37020 (A57222) | Plastic Surgery | Part A and B MAC | Noridian Healthcare Solutions, LLC | AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY |
| L39051 (A58774) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Wisconsin Physicians Service Insurance Corporation | IA, IN, KS, MI, MO, NE |
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| Mastopexy | | | | |
|------------------------------------|---|------------------|--|--|
| Accessed December 6, 2023 | | | | |
| LCD/LCA ID | LCD/LCA Title | Contractor Type | Contractor Name | Applicable States/Territories |
| L39506 (A59299) | Cosmetic and Reconstructive Surgery | Part A and B MAC | CGS Administrators, LLC | KY, OH |
| L38914 (A58573) | Cosmetic and Reconstructive Surgery | Part A and B MAC | First Coast Service Options, Inc. | FL, PR, VI |
| L35001 (A56837) | Reduction Mammoplasty | Part A and B MAC | National Government Services, Inc. | CT, IL, MA, ME, MN, NH, NY, RI, VT, WI |
| L35163 (A57221) | Plastic Surgery | Part A and B MAC | Noridian Healthcare Solutions, LLC | AS, CA, GU, HI, MP, NV |
| L37020 (A57222) | Plastic Surgery | Part A and B MAC | Noridian Healthcare Solutions, LLC | AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY |
| L35090 (A56587) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Novitas Solutions, Inc. | AR, CO, DC, DE, TX, LA, MS, MD, NJ, NM, OK, PA |
| L33428 (A56658) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Palmetto GBA | AL, GA, NC, SC, TN, VA, WV |
| L39051 (A58774) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Wisconsin Physicians Service Insurance Corporation | IA, IN, KS, MI, MO, NE |
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| Gynecomastia Surgery | | | | |
|---------------------------|---|------------------|------------------------------------|--|
| Accessed December 6, 2023 | | | | |
| LCD/LCA ID | LCD/LCA Title | Contractor Type | Contractor Name | Applicable States/Territories |
| L38914 (A58573) | Cosmetic and Reconstructive Surgery | Part A and B MAC | First Coast Service Options, Inc. | FL, PR, VI |
| L35163 (A57221) | Plastic Surgery | Part A and B MAC | Noridian Healthcare Solutions, LLC | CA, AS, GU, HI, MP, NV |
| L37020 (A57222) | Plastic Surgery | Part A and B MAC | Noridian Healthcare Solutions, LLC | AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY |
| L35090 (A56587) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Novitas Solutions, Inc. | AR, CO, DE, DC, LA, MD, MS, NJ, NM, OK, PA, TX |

| Gynecomastia Surgery | | | | |
|------------------------------------|---|------------------|--|-------------------------------|
| Accessed December 6, 2023 | | | | |
| LCD/LCA ID | LCD/LCA Title | Contractor Type | Contractor Name | Applicable States/Territories |
| L39051 (A58774) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Wisconsin Physicians Service Insurance Corporation | IA, IN, KS, MI, MO, NE |
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| Tattooing to Correct Color Defects of the Skin | | | | |
|--|---|------------------|--|-------------------------------|
| Accessed December 6, 2023 | | | | |
| LCD/LCA ID | LCD/LCA Title | Contractor Type | Contractor Name | Applicable States/Territories |
| L39051 (A58774) | Cosmetic and Reconstructive Surgery | Part A and B MAC | Wisconsin Physicians Service Insurance Corporation | IA, IN, KS, MI, MO, NE |
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| Gender Dysphoria Treatment | | | | |
|------------------------------------|---|------------------|-----------------|-------------------------------|
| Accessed December 6, 2023 | | | | |
| LCD/LCA ID | LCD/LCA Title | Contractor Type | Contractor Name | Applicable States/Territories |
| A53793 | Billing and Coding: Gender Reassignment Services for Gender Dysphoria | Part A and B MAC | Palmetto GBA | AL, GA, NC, SC, TN, VI, WV |
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Policy History/Revision Information

| Date | Summary of Changes |
|------------|---|
| 09/13/2023 | <p>Template Update</p> <ul style="list-style-type: none"> Updated <i>Instructions for Use</i> <p>Coverage Guidelines</p> <ul style="list-style-type: none"> Removed content/language addressing tattooing to correct color defects of the skin (CPT codes 11920, 11921, and 11922) <p>Breast Reconstruction Following Mastectomy</p> <ul style="list-style-type: none"> Updated list of applicable CPT codes for breast implant and tissue expansion; removed 19340 and 19342 <p>Supporting Information</p> <ul style="list-style-type: none"> Archived previous policy version MCS022.08 |

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing the items or services in this coverage summary have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, UnitedHealthcare applies internal coverage criteria in the UnitedHealthcare commercial policies referenced in this coverage summary. The coverage criteria in these commercial policies was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

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