### Coverage Summary

#### Cosmetic and Reconstructive Procedures

<table>
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<th><strong>Products:</strong> UnitedHealthcare Medicare Advantage Plans</th>
<th>Original Approval Date: 08/23/2007</th>
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<td><strong>Approved by:</strong></td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td><strong>Last Review Date:</strong> 08/20/2019</td>
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**Related Medicare Advantage Policy Guidelines:**

- Breast Reconstruction Following Mastectomy (NCD 140.2)
- Cosmetic and Reconstructive Services and Procedures
- Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (NCD 250.5)
- Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)
- Laser Procedures (NCD 140.5)
- Plastic Surgery to Correct “Moon Face” (NCD 140.4)
- Treatment of Actinic Keratosis (NCD 250.4)

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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 is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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      b. Breast Reduction Surgery (Reductive Mammoplasty)
      c. Blepharoplasty
      d. Treatment of Actinic Keratosis
      e. Panniculectomy/Abdominal Lipectomy
      f. Suction-Assisted Lipectomy
      g. Mastopexy
      h. Gynecomastia Treatment
      i. Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS)
      j. Tattooing to Correct Color Defects of the Skin
      k. Myocutaneous Flaps for the Head, Neck, Trunk and Extremities
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I. COVERAGE

Coverage Statement: Cosmetic or reconstructive surgery is covered when Medicare criteria are met.

Guidelines/Notes:
1. 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.
   See Section II (Definitions) for definitions of cosmetic surgery and reconstructive surgery.
2. Examples include but are not limited to:
   a. Breast Reconstruction; see the Coverage Summary for Breast Reconstruction Following Mastectomy.
   b. Breast Reduction Surgery (Reductive Mammoplasty) (CPT code 19318)
      • Medicare does not have a National Coverage Determination (NCD) for reductive mammoplasty.
      • Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist for all 50 states and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment A).
      • Committee approval date: March 19, 2019
      • Accessed November 4, 2019
   c. Blepharoplasty; see the Coverage Summary for Blepharoplasty and Related Procedures.
   d. Treatment of Actinic Keratosis; Medicare covers the destruction of actinic keratosis without restrictions based on lesion or patient characteristics. See the NCD for Treatment of Actinic Keratosis (250.4). (Accessed March 11, 2019)
   e. Panniculectomy/Abdominal Lipectomy (CPT codes 15830 and 15847)
      • 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 state-specific LCDs/LCAs, see the LCD Availability Grid (Attachment B).
      • For states with no LCDs/LCAs, see the UnitedHealthcare Commercial Coverage
Determination Guideline for Panniculectomy and Body Contouring Procedures for coverage guideline.

(IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)

- **Committee approval date:** March 19, 2019
- **Accessed November 4, 2019**

f. **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 state-specific LCDs/LCAs, see the LCD Availability Grid (Attachment C).
   - **For states with no LCDs/LCAs,** see the UnitedHealthcare Commercial Coverage Determination Guideline for Panniculectomy and Body Contouring Procedures for coverage guideline.
     (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - **Committee approval date:** March 19, 2019
   - **Accessed November 4, 2019**

g. **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 50 states and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment D).
   - **Committee approval date:** March 19, 2019
   - **Accessed September 5, 2019**

*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, see the following FDA communication at https://www.fda.gov/news-events/press-announcements/fda-takes-action-protect-patients-risk-certain-textured-breast-implants-requests-allergan?utm_campaign=072419_PR_FDA%20requests%20Allergan%20voluntarily%20recall%20certain%20breast%20implants%20from%20market&utm_medium=email&utm_source=Eloqua. (Accessed August 5, 2019)

For guidelines on services related to and required as a result of services which are not covered under Medicare. See the Coverage Summary for Non-Covered Services (Including Services/Complications Related to Non-Covered Services).

h. **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 state-specific LCDs/LCAs, see the LCD Availability Grid (Attachment E).
• **For coverage guideline,** see the MCG™ Care Guidelines, 23rd edition, 2019, Mastectomy for Gynecomastia ACG: A-0273 (AC) for information regarding medical necessity review.

  (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)

• **Committee approval date:** March 19, 2019

• **Accessed** November 4, 2019

i. **Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS)**

Effective for claims with dates of service on and after March 23, 2010, dermal injections for LDS are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in HIV-infected beneficiaries when LDS caused by antiretroviral HIV treatment is a significant contributor to their depression. See the **NCD for Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS)** (250.5). (Accessed March 11, 2019)

j. **Tattooing to Correct Color Defects of the Skin (CPT codes 11920, 11921 and 11922)**

• *Medicare does not have a National Coverage Determination (NCD) for tattooing to correct color defects of the skin*

• *Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist and compliance with this policy is required where applicable. For state-specific LCDs/LCAs, see the LCD Availability Grid (Attachment F).*

• *For states with no LCDs/LCAs, see the Wisconsin Physicians LCD for Cosmetic and Reconstructive Surgery (L34698) for coverage guideline. (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)*

• **Committee approval date:** March 19, 2019

• **Accessed** November 4, 2019

k. **Myocutaneous Flaps for the Head, Neck, Trunk and Extremities (CPT codes 15731, 15733, 15734, 15736, 15738 and 15756)**

• *Medicare does not have a National Coverage Determination (NCD) for myocutaneous flaps*

• *Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) do not exist at this time.*

• *For coverage guideline, see the UnitedHealthcare Commercial Coverage Determination Guideline for Cosmetic and Reconstructive Procedures.*

  (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)

• **Committee approval date:** March 19, 2019

• **Accessed** September 5, 2019

For **Myocutaneous Flaps related to Breast Reconstruction (CPT codes 19361, 19364, 19366, 19367, 19368 and 19369), refer to the Coverage Summary for Breast Reconstruction Following Mastectomy.**

l. **Toe Polydactyly Reconstruction (CPT code 28344)**

• *Medicare does not have a National Coverage Determination (NCD) for toe polydactyly reconstruction.*

• *Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) do not exist*
m. 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 at this time.
   - For coverage guideline, see the UnitedHealthcare Commercial Coverage Determination Guideline for Pectus Deformity Repair.
     (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: March 19, 2019
   - Accessed September 5, 2019

n. Septoplasty, Rhinoplasty, Vestibular Stenosis Repair and Balloon Sinuplasty; see the Coverage Summary for Nasal and Sinus Procedures.

o. Surgery to Correct Moon Face
   The cosmetic surgery exclusion precludes payment for any surgical procedure directed at improving appearance. The condition giving rise to the patient's preoperative appearance is generally not a consideration. The only exception to the exclusion is surgery for the prompt repair of an accidental injury or for the improvement of a malformed body member which coincidentally serves some cosmetic purpose. Since surgery to correct a condition of "moon face" which developed as a side effect of cortisone therapy does not meet the exception to the exclusion, it is not covered under Medicare. See the NCD for Plastic Surgery to Correct "Moon Face" (140.4). (Accessed August 16, 2019)

p. 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) exists and compliance with this policy is required where applicable. For state-specific LCD/LCA, see the LCD Availability Grid (Attachment G).
   - For coverage guideline, see the UnitedHealthcare Commercial Medical Policy for Gender Dysphoria Treatment.
     (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - For other related cosmetic procedures, refer to the applicable guideline(s) on this Coverage Summary; see the Index above for the list of these guidelines.
   - Committee approval date: March 19, 2019
   - Accessed November 4, 2019
Notes:

- For guidance on diagnosis and treatment of impotence/erectile dysfunction, refer to the NCD for Diagnosis and Treatment of Impotence (230.4) and Coverage Summary for Impotence Treatment.

- 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 for Medications/Drugs (Outpatient/Part B).


As indicated in the above-referenced instruction, in the absence of an NCD, CMS contractors and adjudicators should consider whether any Medicare claims for these items and services are reasonable and necessary under §1862(a)(1)(A) of the Social Security Act consistent with existing guidelines for making such decisions when there is no NCD.

For calendar year 2015, CMS determined that these items and services met the significant cost test, as specified in 42 C.F.R. § 422.109(a)(2). Therefore, for items and services received in calendar year 2015 only, original fee-for-service Medicare will pay for reasonable and necessary items and services obtained by beneficiaries enrolled in MA plans.

Consistent with §1862(a)(1)(A) of the Act, Medicare Administrative Contractors will consider whether transgender surgery services are reasonable and necessary and reimbursable by original Medicare for Medicare beneficiaries enrolled in MA plans in 2015.

- For 2016 calendar year, UnitedHealthcare Medicare Advantage will determine coverage of transgender surgery by individual consideration.

- On August 30, 2016, CMS issued the following decision: The Centers for Medicare & Medicaid Services (CMS) is not issuing a National Coverage Determination (NCD) at this time on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence is inconclusive for the Medicare population. See the Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N). (Accessed August 16, 2019)

q. 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 at this time.

- For coverage guideline, see the UnitedHealthcare Commercial Medical Policy for Light and Laser Therapy.
  (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)

- Committee approval date: March 19, 2019

- Accessed September 5, 2019
r. **Insertion of Tissue Expander for Other Than Breast (CPT code 11960)**

- Medicare does not have a National Coverage Determination (NCD) for insertion tissue expander for other than breast.
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.
- **For coverage guideline, see the UnitedHealthcare Commercial Coverage Determination Guideline for Cosmetic and Reconstructive Procedures.**

  (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)

- Committee approval date: March 19, 2019
- Accessed September 5, 2019

For insertion of tissue expander for breast, see the **Coverage Summary for Breast Reconstruction Following Mastectomy.**

### II. DEFINITIONS


**Reconstructive Surgery:** 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. *Multiple LCDs for Cosmetic and Reconstructive Surgery; available at [http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).* (Accessed March 11, 2019)

### III. REFERENCES
IV. REVISION HISTORY

08/20/2019  Guideline 2.g [Mastopexy (CPT code 19316)]

- Added notation to indicate:
  - For guidelines on services related to and required as a result of services which are not covered under Medicare, see the UnitedHealthcare Medicare Advantage Coverage Summary titled [Non-Covered Services (Including Services/Complicated Related to Non-Covered Services)]

V. ATTACHMENT(S)

**Attachment A - LCD Availability Grid**

**Reductive Mammaplasty**

(CPT code 19318)

CMS website accessed November 4, 2019

**IMPORTANT NOTE:** Use the applicable LCD based on member’s residence/place of service AND type of service.

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<th>LCD Title</th>
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End of Attachment A
### Attachment B - LCD Availability Grid

**Panniculectomy/Abdominal Lipectomy**

(CPT codes 15830 and 15847)

CMS website accessed November 4, 2019

**IMPORTANT NOTE:** Use the applicable LCD based on member’s residence/place of service AND type of service.

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**End of Attachment B**

### Attachment C - LCD Availability Grid

**Suction-Assisted Lipectomy**

(CPT codes 15876, 15877, 15878 and 15879)

CMS website accessed November 4, 2019

**IMPORTANT NOTE:** Use the applicable LCD based on member’s residence/place of service AND type of service.

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**End of Attachment C**
**Attachment D - LCD Availability Grid**

**Mastopexy**

(CPT code 19316)

CMS website accessed November 4, 2019

**IMPORTANT NOTE:** Use the applicable LCD based on member’s residence/place of service AND type of service.

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**End of Attachment D**

**Attachment E - LCD Availability Grid**

**Gynecomastia Treatment**

(CPT code 19300)

CMS website accessed November 4, 2019

**IMPORTANT NOTE:** Use the applicable LCD based on member’s residence/place of service AND type of service.

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<td>Cosmetic and Reconstructive Surgery</td>
<td>MAC - Part A and B</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>IA, IN, KS, MI, MO, NE</td>
</tr>
<tr>
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<td>Cosmetic and Reconstructive Surgery</td>
<td>MAC - Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY</td>
</tr>
<tr>
<td>L35163</td>
<td>Plastic Surgery</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>CA, AS, GU, HI, MP, NV</td>
</tr>
</tbody>
</table>
### Attachment E - LCD Availability Grid
**Gynecomastia Treatment**
(CPT code 19300)
CMS website accessed November 4, 2019

**IMPORTANT NOTE:** Use the applicable LCD based on member’s residence/place of service AND type of service.

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L37020</td>
<td>Plastic Surgery</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
</tr>
</tbody>
</table>

**End of Attachment E**

### Attachment F - LCD Availability Grid
**Tattooing to Correct Color Defects of the Skin**
(CPT codes 11920, 11921 and 11922)
CMS website accessed November 4, 2019

**IMPORTANT NOTE:** Use the applicable LCD based on member’s residence/place of service AND type of service.

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L35090</td>
<td>Cosmetic and Reconstructive Surgery</td>
<td>A and B MAC</td>
<td>Novitas Solutions, Inc.</td>
<td>CO, NM, OK, TX, AR, LA, MS, DE, DC, MD, NJ, PA</td>
</tr>
<tr>
<td>L34698</td>
<td>Cosmetic and Reconstructive Surgery</td>
<td>MAC - Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>IA, IN, KS, MI, MO, NE</td>
</tr>
<tr>
<td>A57475</td>
<td>Cosmetic and Reconstructive Surgery</td>
<td>MAC - Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>WI, WY</td>
</tr>
</tbody>
</table>

**End of Attachment F**

### Attachment G - LCD Availability Grid
**Gender Dysphoria Treatment**
CMS website accessed November 4, 2019

**IMPORTANT NOTE:** Use the applicable LCD based on member’s residence/place of service AND type of service.

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>A53793</td>
<td>Billing and Coding: Gender Reassignment Services for Gender Dysphoria</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, SC, TN, VI, WV</td>
</tr>
</tbody>
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