# Coverage Summary

## Cosmetic and Reconstructive Procedures

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<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 03/19/2019</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)

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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### 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 the Medicare Benefit Policy Manual, Chapter 16, §120 - Cosmetic Surgery. (Accessed March 11, 2019)*

   *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 May 1, 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

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II. DEFINITIONS

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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 (CDG) 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 May 1, 2019

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**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 (CDG) 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 May 1, 2019

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**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 May 1, 2019

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**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 May 1, 2019

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**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 May 1, 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 (CDG) 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 March 11, 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 at this time.
   - For coverage guideline, see the UnitedHealthcare Commercial Coverage Determination Guideline (CDG) 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 March 11, 2019

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 (CDG) 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 March 11, 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 April 5, 2018)

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 May 1, 2019
Notes:
  o 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.
  o 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.

  o For 2016 calendar year, UnitedHealthcare Medicare Advantage will determine coverage of transgender surgery by individual consideration.
  o 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 April 5, 2018)

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 for Cutaneous Lesions and Pilonidal Disease. (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 March 11, 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 (CDG) 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 March 11, 2019

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

II. DEFINITIONS


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04/01/2019

- Updated policy introduction; added language to clarify:
  - There are instances where [the Coverage Summary] 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)
- Retitled reference links that direct users to UnitedHealthcare Commercial policies

03/19/2019

Annual review with the following update:

Guideline 2.h (Gynecomastia Treatment) - updated MCG™ reference from 22nd edition, 2018 to 23rd edition, 2019; no change in MCG™ guideline.
Annual review with the following updates:

Guideline 1 – added a statement to see Section II for definitions of cosmetic and reconstructive surgery.

Definitions – added the following definition based on the available LCDs:

Cosmetic Surgery: Surgery performed to reshape normal structures of the body to improve the patient's appearance and self-esteem. Multiple LCDs for Cosmetic and Reconstructive Surgery.

Re-review with the following update:

Guideline 2.h [Gynecomastia Treatment (CPT code 19300)] - updated the MCG™ reference from 21st edition 2017 to the 22nd edition 2018; no change in MCG™ guideline; no change in the Coverage Summary guideline.

Re-review with the following updates:

Guideline 2.b [Breast Reduction Surgery (Reductive Mammaplasty)] - Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

Guideline 2.e (Panniculectomy/Abdominal Lipectomy) - Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

Guideline 2.f (Suction-Assisted Lipectomy) - Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

11/20/2017

Guideline 2.k [Myocutaneous Flaps for the Head, Neck, Trunk and Extremities (CPT codes 15731, 15733, 15734, 15736, 15756 and 15738)] - removed reference to CPT code 15732 (code deleted effective January 1, 2018); replaced with CPT code 15733.

09/19/2017

Re-review; Guideline 2.9p (Gender Dysphoria Treatment) was updated to include the following note:

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.

04/18/2017

Annual review; no updates.

03/21/2017

Re-review with the following updates:

Guideline 2.h (Gynecomastia Treatment) - updated reference from MCG 20th 2016 to 21st 2017 edition.

Guideline 2.p (Gender Dysphoria Treatment)

- Deleted the following:

  Medicare does not have a National Coverage Determination (NCD) for gender dysphoria treatment.

- Added the following:

  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.

01/17/2017  Re-review with the following recommended update:
Guideline 2.p (Gender Dysphoria Treatment) – added the following note and reference link:

*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.*

12/20/2016  Re-review with the following update:
Guideline 2.p (Gender Dysphoria Treatment) – updated the note pertaining to hormone therapy to read:

*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).*

11/15/2016  Re-review with the following update:
Guideline 2.p (Gender Dysphoria Treatment) – updated to include the following statement pertaining to hormone replacement therapy with reference link to the Coverage Summary for Medications/Drugs (Outpatient/Part B):

*For hormone replacement therapy, Part B vs Part D coverage rules apply. For Part B vs Part D medication coverage guideline, refer to the Coverage Summary for Medications/Drugs (Outpatient/Part B).*

09/20/2016  Re-review with the following updates:
Guideline 2.p (Transgender Surgery)
- Changed guideline title to “Gender Dysphoria Treatment” and added guideline with default policy for states with no LCDs to the UnitedHealthcare Medical Policy for Gender Dysphoria Treatment (effective January 1, 2017)
- Added the following note:

*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).*

07/26/2016  Re-review with the following updates:
Guideline 2.r (Insertion of Tissue Expander for Other Than Breast) – added
guideline; new to the policy.

04/19/2016  All LCD Availability Grids updated.


02/16/2016  Annual review; with following recommended update(s):
- Guideline 2.b (Breast Reduction Surgery) - Updated guideline to state that all states now have LCDs; deleted reference to the MCG™ Care Guidelines, 19th edition, 2015 Reduction Mammoplasty (Mammoplasty) ACG: A-0274 (AC) as default guideline for state with no LCDs
- Guideline 2.g (Mastopexy) - Updated guideline to state that all states now have LCDs; deleted reference to the UnitedHealthcare Coverage Determination Guidelines for Breast Reduction Surgery as default guideline for state with no LCDs; removed the cross reference link to the Coverage Summary for Breast Reconstruction Following a Mastectomy (cross reference link already in Guideline 2.a)
- Guideline 2.h (Gynecomastia Treatment) – updated to state that there are now more LCDs available
- Guideline 2.j (Tattooing to correct color defects of the skin) - Current default guideline for states with no LCDs is the UnitedHealthcare Coverage Determination Guideline for Breast Reduction. There are now 2 MACS with LCDs with identical guidelines (Wisconsin L34698 and Novitas L35090); together these 2 LCDs cover 47 states which is > 80% of the geographic area; changed default guideline for states with no LCDs from UnitedHealthcare Coverage Determination Guideline for Breast Reduction Surgery to Wisconsin Physicians LCD for Cosmetic Surgery (L34698); removed cross reference link to the Coverage Summary for Breast Reconstruction Following a Mastectomy (cross reference link already in Guideline 2.a)
- Guideline 2.p (Transgender Surgery)
  o Deleted the following:
    For the calendar year 2015, CMS has determined that the UnitedHealthcare Medicare Advantage (MA) Plan should not administer claims regarding whether transgender surgery is a covered benefit. For 2015, Medicare will make payments for MA enrollees on a fee-for-service basis for covered transgender surgeries as outlined below. UnitedHealthcare MA members requesting for transgender surgery should be directed to call 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048).

    Claims received with transgender surgery codes should not be paid; these claims should be returned informing providers that the claims should be sent to the appropriate Medicare Administrative Contractor.
  o Added the following: For 2016 calendar year, UnitedHealthcare Medicare Advantage will determine coverage of transgender surgery by individual consideration.
- Updated reference link(s) of the applicable LCDs to reflect the condensed link

10/01/2015  Updated reference link(s) to the applicable Medicare Administrative Contractor
(MAC) LCDs to reflect the new/condensed LCD ID numbering effective October 1, 2015.

09/15/2015 Guideline 2.h [Gynecomastia Treatment (CPT code 19300)] – Replaced LCD for Cosmetic and Reconstructive (L30733) (retired) to Wisconsin LCD for Cosmetic and Reconstructive (L34698).

Guideline 2.q (Light and Laser Therapy for Rosacea and Rhinophyma) – Added applicable guideline (new to this CS).

05/19/2015 Guideline 2.m (Transgender Surgery) – Added guideline based on the April 20, 2015 letter of clarification received by UnitedHealthcare Legal and Regulatory Affairs from CMS Health Plan Management System (HPMS).

04/21/2015 Annual review with the following updates:

Guideline 2. b (Breast Reduction Surgery (Reductive Mammoplasty)
• Changed default guideline for states with no LCDs from UnitedHealthcare Coverage Determination Guidelines for Breast Reduction Surgery to MCG™ Care Guidelines, 19th edition, 2015, Reduction Mammoplasty (Mammoplasty) ACG: A-0274 (AC).

Guideline 2.e (Panniculectomy/Abdominal Lipectomy)
• Changed default guideline for states with no LCDs from Palmetto LCD for Cosmetic and Reconstructive Surgery (L31784) to MCG™ Care Guidelines, 19th edition, 2015, Panniculectomy ACG:A-0498 (AC) and Abdominoplasty ACG: A-0497 (AC).

Guideline 2.f (Suction-Assisted Lipectomy)
• Removed the statement “Indications for coverage within available LCDs vary.”

Guideline 2.g (Mastopexy)
• Changed default guideline for states with no LCDs from Wisconsin LCD for Cosmetic and Reconstructive Surgery Cosmetic and Reconstructive Surgery (L30733) to UnitedHealthcare Coverage Determination Guidelines for Breast Reduction Surgery

Guideline 2.g (Gynecomastia Treatment)
• Changed default guideline for states with no LCDs from UnitedHealthcare Coverage Determination for Gynecomastia Treatment to MCG™ Care Guidelines, 19th edition, 2015,

Guideline 2.j (Tattooing to correct color defects of the skin)
• Changed default guideline for states with no LCDs from Wisconsin LCD for Cosmetic and Reconstructive Surgery (L30733) to UnitedHealthcare Coverage Determination Guidelines for Breast Reduction Surgery.

08/19/2014 Guideline #2.k (Myocutaneous Flaps for the Head, Neck, Trunk and Extremities)- Added CPT codes 15731 and 15756

Guideline #2.p (Transsexual Surgery)-Guideline removed from the Coverage Summary based on the June 27, 2014 CMS Transmittal Change Request 8825 Invalidation of National Coverage Determination 140.3 - Transsexual Surgery;
Annual review with the following updates:

- Guideline #2.g [Mastopexy (CPT code 19316)] - Changed default from UnitedHealthcare Coverage Determination Guidelines for Breast Repair/Reconstruction Not Following Mastectomy (no longer addresses CPT code 19316) to Wisconsin LCD L30733.

- Definitions
  - Cosmetic Surgery (removed; already defined in Guideline #1)
  - Information when using Schnur Nomogram Chart (removed; already defined in the default policy for Guideline #2.b, i.e., UnitedHealthcare Coverage Determination for Breast Reduction Surgery)
  - Mastectomy (removed; mastectomy guidelines not addressed on this policy)
  - Moon Face (removed; already defined in Guideline #2.o)
  - Reconstructive Surgery (updated; added reference to the multiple LCDs for Cosmetic and Reconstructive Surgery)
  - Transsexual Surgery (moved to Guideline #2.p)
  - Transsexuals (moved to Guideline #2.p)

02/20/2013 Guidelines #1.f (Suction-Assisted Lipectomy) - Changed section title to Myocutaneous Flaps for the Head, Neck, Trunk and Extremities.

02/25/2014 Annual review with the following updates:

- Guidelines #1.b (Breast Reduction Surgery/Reductive Mammaplasty) - Default guidelines for states with no LCDs replaced with the direct link to the September 1, 2012 UnitedHealthcare Coverage Determination Guidelines for Breast Reduction Surgery.

- Guidelines #1.e (Panniculectomy/Lipectomy) - New section for Panniculectomy/Lipectomy with Palmetto LCD for Cosmetic and Reconstructive Surgery (L31784) as the default guidelines for states with no LCDs. Deleted the separate sections for Panniculectomy, Abdominoplasty, and Lipectomy.

- Guidelines #1.f (Suction-Assisted Lipectomy of the Trunk) - Replaced the default guidelines for states with no LCDs from the UnitedHealthcare Coverage Determination Guidelines for Panniculectomy and Body Contouring Procedures to the Palmetto LCD for Plastic Surgery (L28291). Added reference to the CPT codes 19361, 19364, 19366, 19367, 19368 and 19369.
• Guidelines #1.g (Mastopexy) - Default guidelines for states with no LCDs replaced with the direct link to the November 12, 2012 UnitedHealthcare Coverage Determination Guidelines for Breast Repair/Reconstruction Not Following Mastectomy.
• Guidelines #1.h (Gynecomastia) - Default guidelines for states with no LCDs replaced with the direct link to the February 1, 2012 UnitedHealthcare Coverage Determination Guidelines for Gynecomastia Treatment.
• Guidelines #1.k (Strabismus Repair in Adults) - Default guidelines changed from the UnitedHealthcare Coverage Determination Guidelines for Cosmetic and Reconstructive Procedures to the April 1, 2013 UnitedHealthcare Coverage Determination Guidelines for Cosmetic and Reconstructive Procedures.
• Guidelines 1.l (Myocutaneous Flaps) - Default guidelines for states with no LCDs replaced with the direct link to the April 1, 2013 UnitedHealthcare Coverage Determination Guidelines for Cosmetic and Reconstructive Procedures.
• Guidelines #1.m Toe Polydactyly Reconstruction (CPT code 28344) - Default guidelines for states with no LCDs replaced with the direct link to the April 1, 2013 UnitedHealthcare Coverage Determination Guidelines for Cosmetic and Reconstructive Procedures.

10/31/2012 Updated to include the following guidelines:
• Guidelines 1.m - Strabismus Repair in Adults
• Guidelines 1.n - Myocutaneous Flaps
• Guidelines 1.o - Toe Polydactyly Reconstruction
• Guidelines 1.p - Pectus Deformity Repair

12/19/2011
• Guidelines #2.b Breast Reduction Surgery – updated guidelines based on the UHC CDG for Breast Reduction Surgery effective December 1, 2011.
• Guidelines 2.e Panniculectomy - updated guidelines based on the UHC CDG for Panniculectomy and Body Contouring Procedures effective November 1, 2011.
• Guidelines 2.j Gynecomastia - updated guidelines based on the UHC CDG for Gynecomastia effective February 1, 2012.

06/30/2011 Added Guidelines #2.1 - Tattooing to correct color defects of the skin.

04/08/2011 LCD Availability Grid (Attachment A) updated.

11/16/2010 Policy updated to include coverage guidelines for the following: panniculectomy, abdominoplasty, lipectomy, suction assisted lipectomy of the trunk, mastopexy, and gynecomastia; based on the UHC CDGs effective December 1, 2010.

07/19/2010 Policy updated to include the new NCD for Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (250.5).
### Attachment A - LCD Availability Grid

**Reductive Mammaplasty**

(CPT code 19318)

CMS website accessed May 1, 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>L33428</td>
<td>Cosmetic and Reconstructive Surgery</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
</tr>
<tr>
<td>L34698</td>
<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>
<td>L34698</td>
<td>Cosmetic and Reconstructive Surgery</td>
<td>MAC – Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>AK, AL, AR, AZ, CT, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, OH, OR, RI, SC, SD, TN, UT, VA, VI, VT, WA, WI, WV, WY</td>
</tr>
<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>
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<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>
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<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>
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<td>L35001</td>
<td>Reduction Mammaplasty</td>
<td>A and B MAC</td>
<td>National Government Services, Inc.</td>
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<td>L32939</td>
<td>Reduction Mammaplasty</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
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End of Attachment A

### Attachment B - LCD Availability Grid

**Panniculectomy/Abdominal Lipoectomy**

(CPT codes 15830 and 15847)

CMS website accessed May 1, 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>
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<tbody>
<tr>
<td>L33428</td>
<td>Cosmetic and Reconstructive Surgery</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>NC, SC, VA, WV, AL, GA, TN</td>
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<td>L34698</td>
<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>
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<tr>
<td>L34698</td>
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<td>MAC – Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
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</table>
## Attachment B - LCD Availability Grid
### Panniculectomy/Abdominal Lipectomy
(CPT codes 15830 and 15847)
CMS website accessed May 1, 2019

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

<table>
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<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
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<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>
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<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>
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<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>
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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 May 1, 2019

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

<table>
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<th>States</th>
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<td>Palmetto GBA</td>
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<td>L33777</td>
<td>Noncovered Services</td>
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<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
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<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>
<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>
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End of Attachment C

## Attachment D - LCD Availability Grid
### Mastopexy
(CPT code 19316)
CMS website accessed May 1, 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>
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<th>States</th>
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<tbody>
<tr>
<td>L33428</td>
<td>Cosmetic and Reconstructive Surgery</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>NC, SC, VA, WV AL, GA, TN</td>
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<tr>
<td>L34698</td>
<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>
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<td>L34698</td>
<td>Cosmetic and Reconstructive Surgery</td>
<td>MAC – Part A</td>
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<td>AK, AL, AR, AZ, CT, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, ME,</td>
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### Attachment D - LCD Availability Grid

**Mastopexy**  
(CPT code 19316)  
CMS website accessed May 1, 2019

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

<table>
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<tr>
<th>LCD ID</th>
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<td>A and B MAC</td>
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<td>Plastic Surgery</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>CA, AS, GU, HI, MP, NV</td>
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<td>Plastic Surgery</td>
<td>A and B MAC</td>
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<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
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<td>L35001</td>
<td>Reduction Mammaplasty</td>
<td>A and B MAC</td>
<td>National Government Services, Inc.</td>
<td>IL, MN, WI, CT, NY, ME, MA, NH, RI, VT</td>
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**End of Attachment D**

### Attachment E - LCD Availability Grid

**Gynecomastia Treatment**  
(CPT code 19300)  
CMS website accessed May 1, 2019

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

<table>
<thead>
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<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 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>
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<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>
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<td>L37020</td>
<td>Plastic Surgery</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
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**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 May 1, 2019

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

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<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
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<tbody>
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<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>
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<tr>
<td>L34698</td>
<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>
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<tr>
<td>L34698</td>
<td>Cosmetic and Reconstructive Surgery</td>
<td>MAC – Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>AK, AL, AR, AZ, CT, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, OH, OR, RI, SC, SD, TN, UT, VA, VI, VT, WA, WI, WV, WY</td>
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</table>

**End of Attachment F**

### Attachment G - LCD Availability Grid

**Gender Dysphoria Treatment**  
CMS website accessed May 1, 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>
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<td>A53793</td>
<td>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>
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**End of Attachment G**