Coverage Summary

Cosmetic and Reconstructive Procedures

<table>
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<tr>
<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 01/19/2021</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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The benefit information in this Coverage Summary is based on existing national coverage policy, however Local Coverage Determinations (LCDs) may exist and comply 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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   1. General Coverage Guidelines
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      b. Breast Reduction Surgery (Reductive Mammaplasty)
      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
      l. Toe Polydactyly Reconstruction
      m. Pectus Deformity Repair
      n. Septoplasty, Rhinoplasty, Vestibular Stenosis Repair and Balloon Sinuplasty
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 states/territories and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the LCD/LCA Availability Grid (Attachment A).
      - Committee approval date: March 17, 2020
      - Accessed January 14, 2021
   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 9, 2020)
   e. Panniculectomy/Abdominal Lipoectomy (CPT codes 15830 and 15847)
      - Medicare does not have a National Coverage Determination (NCD) for panniculectomy/liposuction.
      - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, see the LCD/LCA Availability Grid (Attachment B).
      - For coverage guidelines for states/territories with no LCDs/LCAs, see the
Gynecomastia (Including Services/Complications Related to Non-Covered Services)

- Committee approval date: March 17, 2020
- Accessed January 14, 2021

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 specific LCDs/LCAs, see the LCD/LCA Availability Grid (Attachment C).
- For coverage guidelines for states/territories with no LCDs/LCAs, see the UnitedHealthcare Commercial Coverage Determination Guideline for Panniculectomy and Body Contouring Procedures. (IMPORTANT NOTE: After checking the LCD/LCA Availability Grid and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)
- Committee approval date: March 17, 2020
- Accessed January 14, 2021

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 and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the LCD/LCA Availability Grid (Attachment D).
- For coverage guidelines for states/territories with no LCDs/LCAs, see the UnitedHealthcare Commercial Coverage Determination Guideline for Breast Reconstruction Post Mastectomy and Poland Syndrome. (IMPORTANT NOTE: After checking the LCD/LCA Availability Grid and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)
- Committee approval date: July 21, 2020
- Accessed January 14, 2021

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:


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 specific LCDs/LCAs, see the LCD/LCA Availability Grid (Attachment E).

• For coverage guidelines for states/territories with no LCDs/LCAs, see the UnitedHealthcare Commercial Coverage Determination Guideline for Gynecomastia Treatment. (IMPORTANT NOTE: After checking the LCD/LCA Availability Grid and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)

• Committee approval date: January 19, 2021
• Accessed January 14, 2021

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 9, 2020)

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 specific LCDs/LCAs, see the LCD/LCA Availability Grid (Attachment F).

• For coverage guidelines for states/territories with no LCDs/LCAs, see the UnitedHealthcare Commercial Coverage Determination Guideline for Breast Reconstruction Post Mastectomy and Poland Syndrome. (IMPORTANT NOTE: After checking the LCD/LCA Availability Grid and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)

• Committee approval date: January 19, 2021
• Accessed January 14, 2021

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 guidelines, see the UnitedHealthcare Commercial Coverage Determination Guideline for Cosmetic and Reconstructive Procedures. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)

• Committee approval date: March 17, 2020
• Accessed March 9, 2020

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
polydactylly reconstruction.

- **Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) do not exist at this time.**
- **For coverage guidelines**, see the UnitedHealthcare Commercial Coverage Determination Guideline for Cosmetic and Reconstructive Procedures. *(IMPORTANT NOTE: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)*

- **Committee approval date: March 17, 2020**
- Accessed March 9, 2020

**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 guidelines**, see the UnitedHealthcare Commercial Coverage Determination Guideline for Pectus Deformity Repair. *(IMPORTANT NOTE: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)*

- **Committee approval date: March 17, 2020**
- Accessed March 9, 2020

**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 March 9, 2020)*

**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) exist and compliance with this policy is required when applicable. For specific LCD/LCA, see the LCD/LCA Availability Grid (Attachment G).
- **For coverage guidelines for states/territories with no LCDs/LCAs, see the UnitedHealthcare Commercial Medical Policy for Gender Dysphoria Treatment.** *(IMPORTANT NOTE: After checking the LCD/LCA Availability Grid and searching the Medicare Coverage Database, if no 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 17, 2020**
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. (Accessed March 9, 2020)
- 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).

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 guidelines, see the UnitedHealthcare Commercial Medical Policy for Light and Laser Therapy. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)
- Committee approval date: March 17, 2020
- Accessed March 9, 2020

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 guidelines, see the UnitedHealthcare Commercial Coverage Determination Guideline for Cosmetic and Reconstructive Procedures. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.)
- Committee approval date: March 17, 2020
- Accessed March 9, 2020

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 9, 2020)
### III. REFERENCES

### IV. REVISION HISTORY

01/19/2021  **Guideline 2.h [Gynecomastia Treatment (CPT code 19300)]**
- Revised default guidelines for states/territories with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs):
  - Added reference link to the UnitedHealthcare Commercial Coverage Determination Guideline titled *Gynecomastia Treatment*
  - Removed reference link to the “MCG™ Care Guidelines, 24th edition, 2020, for *Mastectomy for Gynecomastia ACG: A-0273 (AC)*”

**Guideline 2.j [Tattooing to Correct Color Defects of the Skin (CPT codes 11920, 11921, and 11922)]**
- Revised default guidelines for states/territories with no LCDs/LCAs:
  - Added reference link to the UnitedHealthcare Commercial Coverage Determination Guideline titled *Breast Reconstruction Post Mastectomy and Poland Syndrome*
  - Removed reference link to the Wisconsin Physician Insurance Corporation (WPS) LCD for *Cosmetic and Reconstructive Surgery (L34698)*

### V. ATTACHMENTS

#### Attachment A – LCD/LCA Availability Grid

**Reductive Mammoplasty**

CMS website accessed January 14, 2021

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### Attachment A – LCD/LCA Availability Grid

**Reductive Mammaplasty**

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*Note: States notated with an asterisk should follow the other available state-specific LCD/LCA listed on this grid. This WPS LCD/LCA only applies to states without asterisk.*

End of Attachment A

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### Attachment B – LCD/LCA Availability Grid

**Panniculectomy/Abdominal Lipectomy**

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End of Attachment B
### Attachment C – LCD/LCA Availability Grid
#### Suction-Assisted Liposuction

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### End of Attachment C

### Attachment D – LCD/LCA Availability Grid
#### Mastopexy

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### Attachment D – LCD/LCA Availability Grid

**Reconstructive Surgery**

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**End of Attachment D**

### Attachment E – LCD/LCA Availability Grid

**Gynecomastia Treatment**

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**Note:** States notated with an asterisk should follow the other available state-specific LCD/LCA listed on this grid. This WPS LCD/LCA only applies to states without asterisk.

**End of Attachment E**

### Attachment F – LCD/LCA Availability Grid

**Tattooing to Correct Color Defects of the Skin**

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### Attachment F – LCD/LCA Availability Grid
**Tattooing to Correct Color Defects of the Skin**

CMS website accessed January 14, 2021

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<th>Contractor Type</th>
<th>Contractor</th>
<th>States/Territories</th>
</tr>
</thead>
</table>
| L34698    | Cosmetic and Reconstructive Surgery    | MAC Part B      | Wisconsin Physicians Service Insurance Corporation | TX, UT, VA, VT, WA, WI, WV, WY   
(Note: States notated with an asterisk should follow the other available state-specific LCD/LCA listed on this grid. This WPS LCD/LCA only applies to states without asterisk.) |

**End of Attachment F**

### Attachment G – LCD/LCA Availability Grid
**Gender Dysphoria Treatment**

CMS website accessed January 14, 2021

<table>
<thead>
<tr>
<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States/Territories</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>
</table>

**End of Attachment G**