Cosmetic and Reconstructive Services and Procedures

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➲ Terms and Conditions

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Policy Summary

➲ See Purpose

Overview

The purpose of this policy is to clarify coverage of cosmetic vs. reconstructive surgical procedures. Section 1862(a) (1) (A) of Title XVIII of the Social Security Act provides in part that "...no payment may be made under Part A or B (of Medicare) for any expenses incurred for items or services which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Guidelines

According to the American Society of Plastic Surgeons, the specialty of plastic surgery includes cosmetic and reconstructive procedures:

- Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Surgery performed purely for the purpose of enhancing one's appearance is not covered.
- Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, involutional defects, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

Cosmetic Clinical Indications

- Surgery performed to treat psychiatric or emotional problems is generally not covered;
- Corrective facial surgery is usually not covered when there is no functional impairment present. However, some congenital, acquired, traumatic or developmental anomalies may not result in functional impairment, but are so severely disfiguring as to merit consideration for corrective surgery;
- A mastopexy unrelated to breast reconstruction following a medically necessary mastectomy;
- Cosmetic surgery to reshape the breasts to improve appearance is not a covered benefit. Cosmetic signs and/or symptoms would include ptosis, poorly fitting clothing and member perception of unacceptable appearance;
- Liposuction used for body contouring, weight reduction or the harvest of fat tissue for transfer to another body region for alteration of appearance or self-image or physical appearance;
- Mastectomy for gynecomastia when performed solely to improve appearance of the male breast or to alter contours of the chest wall;

- Rhinoplasty/Nasal surgery is not covered when performed for either of the following:
  - Solely to improve the patient's appearance in the absence of any signs and/or symptoms of functional abnormalities.
  - As a primary treatment for an obstructive sleep disorder.
- Chemical Peel when done for a cosmetic reason;
- Dermabrasion performed for post-acne scarring is classified as cosmetic and is not covered;
- Rhytidectomy is generally considered a cosmetic procedure;
- Panniculectomy is considered experimental and investigational for minimizing the risk of hernia formation or recurrence. There is no evidence that pannus contributes to hernia formation. The primary cause of hernia formation is an abdominal wall defect or weakness, not a pulling effect from a large or redundant pannus;
- Abdominal lipectomy/Panniculectomy when performed primarily for any of the following indications because it is considered not medically necessary (this list may not be all-inclusive):
  - Improving appearance.
  - Repairing abdominal wall laxity or diastasis recti.
  - When performed in conjunction with abdominal or gynecological procedures (e.g., abdominal hernia repair, hysterectomy, obesity surgery) unless criteria for panniculectomy and abdominoplasty are met separately.
- If a non-covered cosmetic surgery is performed in the same operative period as a covered surgical procedure, benefits will be provided for the covered surgical procedure only.

For the following services, Medicare does not have a National Coverage Determination (NCD). 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 located in the *References* section.

- Abrasion; single lesion (e.g., keratosis, scar) (CPT code 15786).
- Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure) (CPT code 15787).
- Ear piercing (CPT code 69090).
- Injection, deoxycholic acid, 1 mg (CPT code J0591).

Reconstructive Clinical Indications

- Breast reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy;
- Reduction mammoplasty is limited to circumstances in which:
  - There are signs and/or symptoms resulting from the enlarged breasts (macromastia) that have not responded adequately to Non-Surgical Interventions, or
  - To improve symmetry following cancer surgery on one breast;
- A medically reasonable and necessary reduction mammoplasty could be indicated in the presence of significantly enlarged breasts and the presence of at least one of the following signs and/or symptoms:
  - Back, neck or shoulder pain from macromastia and unrelieved by:
    - Conservative analgesia,
    - Supportive measures (garment, etc.),
    - Physical Therapy;
  - Significant arthritic changes in the cervical or upper thoracic spine, optimally managed with persistent symptoms and/or significant restriction of activity;
  - Intertriginous maceration or infection of the inflammatory skin refractory to dermatologic measures; or
  - Permanent shoulder grooving with skin irritation by supporting garment (bra strap).
- Removal of a breast implant(s) is considered medically necessary when it is removed for one of the following reasons:
  - Mechanical complication of breast prosthesis; including rupture or failed implant;
  - Infection or inflammatory reaction due to a breast prosthesis; including infected breast implant, or rejection of breast implants;
  - Implant extrusion;
  - Siliconoma or granuloma;
  - Interference with diagnosis of breast cancer; or
  - Painful capsular contracture with disfigurement.
- Mastectomy with nipple preservation or reduction mammoplasty is considered reconstructive for males with gynecomastia Grade III and IV or abnormal breast development with redundancy;
- Tattooing to correct color defects of the skin may be considered reconstructive when performed in connection with a payable post-mastectomy reconstruction, or for reconstruction following trauma or removal of cancer from an eyelid, eyebrow or lip(s);

- Punch graft hair transplant may be considered reconstructive when it is performed for eyebrow(s) or symmetric hairline replacement following a burn injury, trauma or tumor removal;
- Chemical Peel is covered for the treatment of actinic keratosis;
- Dermabrasion coverage will be provided when correcting defects resulting from traumatic injury, surgery or disease;
- Segmental dermabrasion of the face is covered for the treatment of rhinophyma;
- Dermal injections for facial Lipodystrophy Syndrome (LDS) using dermal fillers approved by the FDA for this purpose, and then only in HIV-infected members who manifest depression secondary to the physical stigma of HIV treatment will be covered;
- Abdominal lipectomy/Panniculectomy is considered reconstructive when performed to alleviate complicating factors such as:
  - Inability to walk normally due to pannus size;
  - Chronic pain; and/or
  - Ulceration created by the abdominal skin fold or intertrigo dermatitis.
- Suction assisted lipectomy to remove a lipoma. The clinical record must clearly demonstrate medical necessity for the lipoma removal as most such tumors are benign and do not require removal;
- Nasal surgery generally performed to improve the following:
  - Respiratory function (e.g., airway obstruction or stricture, synechia formation);
  - Repair defects caused by trauma (e.g., nasoseptal deviation, intranasal cicatrix, dislocated nasal bone fractures, turbinate hypertrophy);
  - Treat nasal cutaneous disease (e.g., rhinophyma, dermoid cyst);
  - Treat congenital anatomic anomalies (e.g., cleft lip nasal deformities, choanal atresia, oronasal or oromaxillary fistula); and/or
  - Replace nasal tissue lost after tumor ablation.
- Rhinoplasty is considered medically reasonable and necessary when the procedure is performed for correction or repair of any of the following:
  - Nasal deformity secondary to a cleft lip/palate or other congenital craniofacial deformity causing a functional impairment.
  - Chronic, non-septal, nasal obstruction due to vestibular stenosis (i.e., collapsed internal valves).
  - Secondary to trauma, disease, congenital defect with nasal airway obstruction that has not resolved after previous septoplasty/turbinectomy or would not be expected to resolve with septoplasty/turbinectomy alone.
- Septoplasty is considered medically necessary when performed for any of the following indications:
  - Septal deformity/deviation causing nasal airway obstruction that has proved unresponsive to a recent trial of conservative medical management (e.g., topical nasal corticosteroids, nasal decongestants, nasal dilators). This includes nasal airway obstructions that interfere with the effective use of medically necessary Continuous Positive Airway Pressure (CPAP) for the treatment of an obstructive sleep disorder.
  - Recurrent sinusitis secondary to a deviated septum that does not resolve after appropriate medical and antibiotic therapy.
  - Recurrent epistaxis related to a septal deformity.
  - Asymptomatic septal deformity that prevents access to other transnasal areas when such access is required to perform medically necessary procedures (e.g., ethmoidectomy).
  - Performed in association with cleft lip or cleft palate repair.

For the following services, Medicare does not have a National Coverage Determination (NCD). 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 located in the References section.

- Adjacent Tissue Transfer (CPT codes 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 14301, 14302).
- Autologous Soft Tissue and Fat Grafting (CPT codes 15769, 15771, 15772, 15773, 15774).
- Myocutaneous Flaps (CPT codes 15570, 15572, 15574, 15731, 15734, 15736, 15738, 15740, 15756).

For the following services, Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Rhinoplasty and Other Nasal Surgeries located in the References section.

- Surgery for Rhinophyma (CPT code 30120).

Documentation Requirements

For all procedures:

- All documentation must be maintained in the patient's medical record and made available upon request.
- Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
- The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.
- The medical record documentation must support the medical necessity of the services as stated in this policy.

Reduction Mammoplasty:
The medical record must contain the following information, and be made available upon request:

- Height and weight.
- Clinical evaluation of the signs and/or symptoms ascribed to the macromastia, therapies prior to reduction mammoplasty and the responses to these therapies.
- The operative report with documentation of the weight of tissue removed from each breast, obtained in the operating room.
- The pathology report of the tissue removed from each breast.

Abdominal Lipectomy/Panniculectomy:
The medical record must contain the following information, and be available for review on request:

- Description of the pannus and the underlying skin.
- Description of conservative treatment undertaken and its results.

Punch graft hair transplants: Pre-operative photographs must be made available upon request.

Tattooing or to correct color defects of the skin must indicate the prior condition i.e., post-mastectomy, trauma necessitating the reconstruction in the progress notes.

Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

Services "related to" cosmetic surgery including services related to follow-up care and complications of non-covered services which require treatment during a hospital stay, in which the non-covered service was performed, are not covered services under Medicare.

After a member has been discharged from the hospital stay in which the member received non-covered services, medical and hospital services required to treat a condition or complication that arises as a result of the prior non-covered services may be covered when they are reasonable and necessary in all other respects. Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous non-covered procedure. Some examples of services that may be found to be covered under this policy are the reversal of intestinal bypass surgery for obesity, complications from cosmetic surgery, removal of a non-covered breast prosthesis, or treatment of any infection at the surgical site of a cosmetic procedure that occurred following discharge from the hospital. However, any subsequent services that could be expected to have been incorporated into a global fee are not covered. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's progress, these visits are not covered.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
Abdominal Lipectomy/Panniculectomy [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]	
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15877	Suction assisted lipectomy; trunk
Adjacent Tissue Transfer	
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
Autologous Soft Tissue and Fat Grafting [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]	
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
Biologic Implant	
15777	Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) (List separately in addition to code for primary procedure) (Deleted 08/01/2023)
Breast Surgery	
19316	Mastopexy [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]

CPT Code	Description
Breast Surgery	
19325	Breast augmentation with implant [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
19355	Correction of inverted nipples
Canthopexy	
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
Chemical Peel: See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)	
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
Dermabrasion: See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)	
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
Hair Transplant: See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)	
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
Mastectomy for Gynecomastia	
19300	Mastectomy for gynecomastia
Myocutaneous Flaps	
15570	Formation of direct or tubed pedicle, with or without transfer; trunk
15572	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs
15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15576	Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral (Deleted 08/01/2023)
15730	Midface flap (i.e., zygomaticofacial flap) with preservation of vascular pedicle(s)
15731	Forehead flap with preservation of vascular pedicle (e.g., axial pattern flap, paramedian forehead flap)
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (i.e., buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15736	Muscle, myocutaneous, or fasciocutaneous flap; upper extremity
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15740	Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel
15750	Flap; neurovascular pedicle [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)] (Deleted 08/01/2023)

CPT Code	Description
Myocutaneous Flaps	
15756	Free muscle or myocutaneous flap with microvascular anastomosis
15757	Free skin flap with microvascular anastomosis [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)] (Deleted 08/01/2023)
15758	Free fascial flap with microvascular anastomosis [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)] (Deleted 08/01/2023)
Oral, Facial and Maxillofacial Reconstruction	
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21121	Genioplasty; sliding osteotomy, single piece [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21122	Genioplasty; Sliding Osteotomies, 2 Or More Osteotomies (e.g., Wedge Excision Or Bone Wedge Reversal For Asymmetrical Chin) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21125	Augmentation, mandibular body or angle; prosthetic material [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21137	Reduction forehead; contouring only [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21181	Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm

CPT Code	Description
Oral, Facial and Maxillofacial Reconstruction	
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21209	Osteoplasty, facial bones; reduction [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (e.g., micro-ophthalmia)
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra and extracranial approach
21270	Malar augmentation, prosthetic material [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
21275	Secondary revision of orbitocraniofacial reconstruction
21295	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach
21296	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach
Other Lipectomy: See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)	
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
Reduction Mammoplasty: See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)	
19318	Breast reduction

CPT Code	Description
Rhinoplasty/Nasal Reconstructive Surgery	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
30420	Rhinoplasty, primary; including major septal repair [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
Surgery for Rhinophyma	
30120	Excision or surgical planing of skin of nose for rhinophyma
Tattooing	
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (list separately in addition to code for primary procedure)
Cosmetic: Possible Provisional Coverage based upon the existing Local Coverage Determination (LCD) for the jurisdiction in which the procedure is performed	
36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk
Cosmetic: The below CPT/HCPCS codes are always considered cosmetic and are never covered.	
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15786	Abrasion; single lesion (e.g., keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (list separately in addition to code for primary procedure)

CPT Code	Description
Cosmetic: The below CPT/HCPCS codes are always considered cosmetic and are never covered.	
15819	Cervicoplasty [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15824	Rhytidectomy; forehead [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15826	Rhytidectomy; glabellar frown lines [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15828	Rhytidectomy; cheek, chin, and neck [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15876	Suction assisted lipectomy; head and neck [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15878	Suction assisted lipectomy; upper extremity [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15879	Suction assisted lipectomy; lower extremity [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
17360	Chemical exfoliation for acne (e.g., acne paste, acid)
17380	Electrolysis epilation, each 30 minutes [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
69090	Ear piercing
69300	Otoplasty, protruding ear, with or without size reduction
J0591	Injection, deoxycholic acid, 1 mg

HCPCS Code	Description
Dermal Injections	
G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)
Q2026	Injection, Radiesse, 0.1 ml
Q2028	Injection, Sculptra, 0.5 mg

ICD Procedure Code	Description
Breast Surgery	
0HST0ZZ	Reposition right breast, open approach
0HSU0ZZ	Reposition left breast, open approach
0HSV0ZZ	Reposition bilateral breast, open approach
0H0T0ZZ	Alteration of right breast, open approach
0H0U0ZZ	Alteration of left breast, open approach
0H0V0ZZ	Alteration of bilateral breast, open approach

Diagnosis Code
Cosmetic and Reconstructive Services and Procedures: Diagnosis Code List □

Definitions

Abdominoplasty: Typically performed for cosmetic purposes, involves the removal of excess skin and fat from the pubis to the umbilicus or above, and may include fascial plication of the rectus muscle diastasis and a neoumbilicoplasty.

American Society of Plastic Surgeons' Gynecomastia Scale:
Grade I: Small breast enlargement with localized button of tissue that is concentrated around the areola.
Grade II: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest.
Grade III: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest with skin redundancy present.
Grade IV: Marked breast enlargement with skin redundancy and feminization of the breast.

Functional or Physical Impairment: A physical or functional or physiological impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

Macromastia (Breast Hypertrophy): An increase in the volume and weight of breast tissue relative to the general body habitus. Breast hypertrophy may adversely affect other body systems: musculoskeletal, respiratory, and integumentary. Unilateral hypertrophy may result in symptoms following contralateral mastectomy.

Non-Surgical Interventions: Non-Surgical interventions preceding reduction mammoplasty should include as appropriate, but are not limited to, the following:
- Determining the macromastia is not due to an active endocrine or metabolic process.
- Determining the symptoms are refractory to appropriately fitted supporting garments, or following unilateral mastectomy, persistent with an appropriately fitted prosthesis or reconstruction therapy at the site of the absent breast.
- Determining that dermatologic signs and/or symptoms are refractory to, or recurrent following, a completed course of medical management.

Panniculectomy: Involves the removal of hanging excess skin/fat in a transverse or vertical wedge but does not include muscle plication, neoumbilicoplasty or flap elevation.

Ratio of Weight to Grams Excised: Considerable attention has been given to the amount of breast tissue removed in differentiating between cosmetic and medically necessary reduction mammoplasty. Arbitrary minimum weight breast tissue removed criteria do not consistently reflect the consequences of mammary hypertrophy in individuals with a unique body habitus. There are wide variations in the range of height, weight and associated breast size that cause symptoms. The amount of tissue that must be removed to relieve symptoms will vary and depend upon these variations. The following are guidelines (not rules) that address the patient's weight and the amount of breast tissue removed:
- 95-119 lbs. 300 grams excised per breast.
- 110-130 lbs. 400 grams excised per breast.
- 130 + lbs. 500 grams excised per breast.

(Refer to Schnur Scale below)

Schnur Scale: For medically necessary reduction mammoplasty the amount of breast tissue to be removed must be proportional to the body surface area (BSA) per the Schnur Scale. If only one breast meets the Schnur scale criteria; breast tissue may be removed from the other breast in order to achieve symmetry.

Body Surface Area (m2)	Average Grams of Tissue per Breast to be Removed
1.40-1.50	218-260
1.51-1.60	261-310
1.61-1.70	311-370
1.71-1.80	371-441

Body Surface Area (m2)	Average Grams of Tissue per Breast to be Removed
1.81-1.90	442-527
1.91-2.00	528-628
2.01-2.10	629-750
2.11-2.20	751-895
2.21-2.30	896-1068
2.31-2.40	1069-1275
2.41-2.50	1276-1522
2.51-2.60	1523-1806
2.61-2.70	1807-2154
2.71-2.80	2155-2568
2.81-2.90	2569-3061
2.91-3.00	3062-3650

Questions and Answers

1	**Q**:	What does cosmetic exclusion mean?
	A:	General Exclusions From Coverage; Cosmetic Surgery (Section 120) states: “Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except 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.”
2	**Q**:	Is prior notification required?
	A:	Please check UnitedHealthcare Online for current status.
3	**Q**:	Why are the blepharoplasty codes not in this policy?
	A:	A separate policy guideline has been developed for Blepharoplasty, Blepharoptosis, and Brow Lift.

References

CMS National Coverage Determinations (NCDs)

NCD 140.2 Breast Reconstruction Following Mastectomy
NCD 140.4 Plastic Surgery to Correct "Moon Face"
NCD 140.9 Gender Dysphoria and Gender Reassignment Surgery
NCD 250.4 Treatment of Actinic Keratosis
NCD 250.5 Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS)

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
Cosmetic and Reconstructive Surgery				
L39506 Cosmetic and Reconstructive Surgery	A59299 Billing and Coding: Cosmetic and Reconstructive Surgery	CGS	KY, OH	KY, OH
L38914 Cosmetic and Reconstructive Surgery	A58573 Billing and Coding: Cosmetic and Reconstructive Surgery	First Coast	FL, PR, VI	FL, PR, VI

LCD	Article	Contractor	Medicare Part A	Medicare Part B
Cosmetic and Reconstructive Surgery				
L35090 Cosmetic and Reconstructive Surgery	A56587 Billing and Coding: Cosmetic and Reconstructive Surgery	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L35163 Plastic Surgery	A57221 Billing and Coding: Plastic Surgery A55684 Response to Comments: Plastic Surgery	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
L37020 Plastic Surgery	A57222 Billing and Coding: Plastic Surgery A55685 Response to Comments: Plastic Surgery	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L33428 Cosmetic and Reconstructive Surgery	A56658 Billing and Coding: Cosmetic and Reconstructive Surgery A53497 Billing and Coding: Oral Maxillofacial Prosthesis	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
L39051 Cosmetic and Reconstructive Surgery	A58774 Billing and Coding: Cosmetic and Reconstructive Surgery	WPS	IA, IN, KS, MI, MO, NE	IA, IN, KS, MI, MO, NE
Reduction Mammaplasty				
L35001 Reduction Mammaplasty	A56837 Billing and Coding: Reduction Mammaplasty	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
Varicose Veins of the Lower Extremity				
L34082 Varicose Veins of the Lower Extremity, Treatment of	A57305 Billing and Coding: Varicose Veins of the Lower Extremity, Treatment of	CGS	KY, OH	KY, OH
L38720 Treatment of Chronic Venous Insufficiency of the Lower Extremities	A58250 Billing and Coding: Treatment of Chronic Venous Insufficiency of the Lower Extremities	First Coast	FL, PR, VI	FL, PR, VI
L33575 Varicose Veins of the Lower Extremity, Treatment of	A52870 Billing and Coding: Treatment of Varicose Veins of the Lower Extremity	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L34010 Treatment of Varicose Veins of the Lower Extremities	A57707 Billing and Coding: Treatment of Varicose Veins of the Lower Extremities A53079 Billing and Coding: Sclerosing of Varicose Veins	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L34209 Treatment of Varicose Veins of the Lower Extremities	A57706 Billing and Coding: Treatment of Varicose Veins of the Lower Extremities A53084 Billing and Coding: Sclerosing of Varicose Veins	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV

LCD	Article	Contractor	Medicare Part A	Medicare Part B
Varicose Veins of the Lower Extremity				
L34924 Treatment of Chronic Venous Insufficiency of the Lower Extremities	A55229 Billing and Coding: Treatment of Chronic Venous Insufficiency of the Lower Extremities	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L39121 Treatment of Varicose Veins of the Lower Extremities	A58876 Billing and Coding: Treatment of Varicose Veins of the Lower Extremities	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
L34536 Treatment of Varicose Veins of the Lower Extremities	A56914 Billing and Coding: Treatment of Varicose Veins of the Lower Extremities	WPS	IA, IN, KS, MI, MO, NE	IA, IN, KS, MI, MO, NE
Gender Reassignment Services				
N/A	A53793 Billing and Coding: Gender Reassignment Services for Gender Dysphoria	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV

CMS Benefit Policy Manual

Chapter 16; § 10 General Exclusions from Coverage, § 120 Cosmetic Surgery, § 180 Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

CMS Claims Processing Manual

Chapter 1, § 60.1 General Information on Noncovered Charges
Chapter 32, § 260 Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)

UnitedHealthcare Commercial Policies

Cosmetic and Reconstructive Procedures
Rhinoplasty and Other Nasal Surgeries

Other(s)

Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 5 Correct Coding Initiative, CMS Website
Social Security Act (Title XVIII) Standard References:

- § 1862 (a)(1)(A) Medically Reasonable & Necessary, (a)(10) Cosmetic Surgery
- § 1833 (e) Incomplete Claim

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
02/23/2024	**Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version MPG065.13

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section above to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

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 policy guideline 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 policy guideline. 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.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.