UnitedHealthcare Medicare Advantage

UnitedHealthcare® Medicare Advantage
Policy Guideline

Cosmetic and Reconstructive Services and Procedures

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➲ Terms and Conditions

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- Blepharoplasty and Related Procedures
- Breast Reconstruction Following Mastectomy
- Cosmetic and Reconstructive Procedures

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 beneficiary perception of unacceptable appearance;

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- 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.

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

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- 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

Coding Guidelines

Flaps (Skin and/or Deep Tissues) Procedures: 15570-15738

- Codes 15733-15738 are described by donor site of the muscle, myocutaneous or fasciocutaneous flap.
- A repair of a donor site requiring a skin graft or local flaps is considered an additional separate procedure.
- CPT codes 15756-15758 represent microvascular flaps.
- CPT codes 15570-15576 represent flaps without inclusion of a vascular pedicle.
- CPT codes 14000-14302 represent flaps for adjacent tissue transfer.
- The regions listed refer to recipient area (not the donor site) when a flap is being attached in a transfer or to a final site.
- Codes 15570-15738 do not include extensive immobilization (e.g., large plaster casts and other immobilizing devices are considered additional separate procedures).

Other Flaps and Grafts Procedures: 15740-15777

- Code 15740 describes a cutaneous flap, transposed into a nearby but not immediately adjacent defect, with a pedicle that incorporates an anatomically named axial vessel into its design. The flap is typically transferred through a tunnel underneath the skin and sutured into its new position. The donor site is closed directly.

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- Neurovascular pedicle procedures are reported with 15750. This code includes not only skin but also a functional motor or sensory nerve(s). The flap serves to re-innervate a damaged portion of the body dependent on touch or movement (e.g., thumb). Repair of donor site requiring skin graft or local flaps should be reported as an additional procedure.
- For random island flaps, V-Y subcutaneous flaps, advancement flaps and other flaps from adjacent areas without clearly defined anatomically named axial vessels; see 14000-14302.

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.

All submitted non-covered or no payment claims using condition code 21 will be processed to completion, and all services on those claims, since they are submitted as non-covered, will be denied. The default liability for payment of these claims is assigned to the beneficiary, who may then submit the denial from Medicare, as the primary payer, to subsequent payer(s) for consideration.

After a beneficiary has been discharged from the hospital stay in which the beneficiary 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.

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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.

Coding Clarification: For Rhytidectomy CPT Codes, refer to the Medicare Advantage Policy Guideline titled Plastic Surgery to Correct "Moon Face" (NCD 140.4).

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	
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia) (Effective 01/01/2020) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]

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CPT Code	Description
Autologous Soft Tissue and Fat Grafting	
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) [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
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)
Breast Surgery: See the Medicare Advantage Policy Guideline titled Breast Reconstruction Following Mastectomy (NCD 140.2) for breast reconstruction CPT codes	
19316	Mastopexy [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
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 Guidelines titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9) and Treatment of Actinic Keratosis (NCD 250.4)	
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
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)

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CPT Code	Description
Myocutaneous Flaps	
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)]
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)]
15758	Free fascial flap with microvascular anastomosis [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
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)]

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CPT Code	Description
Oral, Facial and Maxillofacial Reconstruction	
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
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 [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]

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CPT Code	Description
Other Lipectomy: See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)	
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
Reduction Mammoplasty: See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)	
19318	Breast reduction
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) (Effective 01/01/2021)
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

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CPT Code	Description
Tattooing	
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)]
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 [See also the Medicare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)]
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) [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)
15819	Cervicoplasty [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

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HCPCS Code	Description
Dermal Injections: See also the Medicare Advantage Policy Guideline titled Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (NCD 250.5)	
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
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.

Adjacent Tissue Transfer: A random pattern local flap which is used to fill in nearby or local defect. To be considered an adjacent tissue transfer an incision must be made by the surgeon which results in a secondary defect. Examples include; transposition flaps, advancement flaps and rotation flaps.

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

Cervicoplasty: The physician removes excess skin from the neck area. The physician marks the area to be removed. The skin is incised, and the excess tissue is resected. The skin is reapproximated and sutured in layers.

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

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- 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.

(See 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
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

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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				
L38914 Cosmetic and Reconstructive Surgery	A58573 Billing and Coding: Cosmetic and Reconstructive Surgery	First Coast	FL, PR, VI	FL, PR, VI
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

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LCD	Article	Contractor	Medicare Part A	Medicare Part B
Cosmetic and Reconstructive Surgery				
L39051 Cosmetic and Reconstructive Surgery	A58774 Billing and Coding: Cosmetic and Reconstructive Surgery	WPS	AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	IA, IN, KS, MI, MO, NE
L34698 Cosmetic and Reconstructive Surgery Retired 11/13/2021	A57475 Billing and Coding: Cosmetic and Reconstructive Surgery Retired 11/13/2021			
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 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
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

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LCD	Article	Contractor	Medicare Part A	Medicare Part B
Varicose Veins of the Lower Extremity				
L34536 Treatment of Varicose Veins of the Lower Extremities	A56914 Billing and Coding: Treatment of Varicose Veins of the Lower Extremities	WPS	AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	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

Blepharoplasty, Blepharoptosis and Brow Ptosis Repair
Breast Reconstruction Post Mastectomy and Poland Syndrome
Breast Reduction Surgery
Breast Repair/Reconstruction Not Following Mastectomy
Cosmetic and Reconstructive Procedures
Gender Dysphoria Treatment
Gynecomastia Treatment
Light and Laser Therapy
Liposuction for Lipedema
Omnibus Codes
Orthognathic (Jaw) Surgery
Panniculectomy and Body Contouring Procedures
Plagiocephaly and Craniosynostosis Treatment
Rhinoplasty and Other Nasal Surgeries
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins
Temporomandibular Joint Disorders

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

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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

05/12/2022	**Policy Summary**
	Guidelines
	• Revised language to indicate:
	  ○ According to the American Society of Plastic Surgeons, the specialty of plastic surgery includes [both] 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
	• Removed:
	  ○ Eye surgery that does not correct a functional impairment
	  ○ Nasal surgery performed solely to improve the patient's appearance in the absence of any signs and/or symptoms of functional abnormalities
	  ○ Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty) when performed to improve the patient's appearance
	  ○ Abdominal lipectomy/panniculectomy for treatment of:
	    ▪ Neck or back pain
	    ▪ Psychological symptomatology or psychosocial complaints
	• Replaced:
	  ○ "A mastopexy *performed primarily to lift or reshape the breast and* unrelated to breast reconstruction following a medically necessary mastectomy" with "a mastopexy unrelated to breast reconstruction following a medically necessary mastectomy"
	  ○ "Mastectomy for gynecomastia when *the tissue removed is primarily fatty tissue*" with "mastectomy for gynecomastia when *performed solely to improve appearance of the male breast or to alter contours of the chest wall*"
	  ○ "Dermabrasion *when* performed for *a cosmetic reason (i.e.,* post-acne scarring)" with "dermabrasion performed for post-acne scarring *is classified as cosmetic and is not covered*"
	  ○ "Rhytidectomy *when performed for a cosmetic reason*" with "rhytidectomy *is generally considered a cosmetic procedure*"
	  ○ "*Abdominoplasty* and panniculectomy *are not covered* when performed primarily for any of the [listed] indications because it is considered not medically necessary" with "*abdominal lipectomy*/panniculectomy when performed primarily for any of the [listed] indications because it is considered not medically necessary"
	  ○ "Rhinoplasty *solely for the purpose of changing* appearance" with "rhinoplasty/nasal surgery solely *to improve the patient's* appearance *in the absence of any signs and/or symptoms of functional abnormalities*"
	Reconstructive Clinical Indications
	• Removed:
	  ○ Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty) will be considered reasonable and medically necessary when these procedures are performed due to another surgery being done at the same time and would affect the healing of the surgical incision

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Date	Summary of Changes
	○ Obstructed nasal breathing due to septal deformity or deviation that has proved unresponsive to medical management and is interfering with the effective use of medically necessary Continuous Positive Airway Pressure (CPAP) for the treatment of an obstructive sleep disorder • Replaced: ○ "Reduction mammoplasty to reduce the size of a normal breast to bring it in symmetry with a breast reconstructed after cancer surgery" with "reduction mammoplasty to improve symmetry following cancer surgery on one breast" ○ "Removal *or revision* of breast implant is considered medically necessary when it is removed for one of the following reasons" with "removal of *a* breast *implant(s)* is considered medically necessary when it is removed for one of the following reasons" ○ "Mastectomy *if it is documented that the tissue is primarily breast tissue and not just adipose (fatty tissue)*" with "mastectomy *with nipple preservation or reduction mammoplasty is considered reconstructive for males with gynecomastia Grade III and IV or abnormal breast development with redundancy"* ○ "Punch graft hair transplant may be considered reconstructive when it is performed for eyebrow(s) or symmetric hairline replacement following a burn injury or tumor removal" with "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" ○ "Dermabrasion coverage *may* be provided when correcting defects resulting from traumatic injury, surgery or disease" with "dermabrasion coverage *will* be provided when correcting defects resulting from traumatic injury, surgery or disease" ○ "Abdominal lipectomy/panniculectomy *may be* considered reconstructive when performed to alleviate complicating factors" with "abdominal lipectomy/panniculectomy *is* considered reconstructive when performed to alleviate complicating factors" ○ "Inability to walk normally" with "inability to walk normally *due to pannus size*" ○ "Rhinoplasty, *when there is photographic documentation (all of the following: frontal, lateral, and worm's eye view) of the individual's condition and* the procedure is performed for correction or repair of any of the following" with "rhinoplasty *is considered medically reasonable and necessary when* the procedure is performed for correction or repair of any of the [listed indications]" ○ "Rhinoplasty performed secondary to trauma, disease, congenital defect with nasal airway obstruction *unresponsive to a recent trial of conservative medical management lasting at least six weeks* that has *either* not resolved after previous septoplasty/turbinectomy" with "rhinoplasty performed secondary to trauma, disease, congenital defect with nasal airway obstruction that has not resolved after previous septoplasty/turbinectomy" ○ "Septal deviation causing nasal airway obstruction that has proved unresponsive to a recent trial of conservative medical management *lasting at least six weeks*" with "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"* ***Documentation Requirements*** • Updated list of clinical information/items to be documented in the medical notes, when applicable: **Reduction Mammoplasty** ○ Removed: ▪ The evaluation and management note for the date of service and the note for the day the decision to perform surgery was made ○ Replaced: ▪ "The pathology report *with the weight* of the tissue removed from each breast" with "the pathology report of the tissue removed from each breast" **Abdominal Lipectomy/Panniculectomy** ○ Removed:

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Date	Summary of Changes
	▪ The evaluation and management note in which the decision to perform surgery was made, surgical note and any notes indicating medical complications necessitating the surgery **Applicable Codes** *CPT Codes* **Breast Surgery** • Removed 19324 • Updated notation: ○ Added reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled Breast Reconstruction Following Mastectomy (NCD 140.2) ○ Removed reference link to the UnitedHealthcare Advantage Policy Guideline titled Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9) **Dermabrasion** • Revised description for 15780, 15782, and 15783 **Rhinoplasty/Nasal Reconstructive Surgery** • Added 30520 *Diagnosis Codes* **For CPT codes 15830 and 15847** • Added notation to indicate E65 was "deleted Jul. 10, 2021" **For CPT codes 19325 and 19355** • Added C84.7A, T85.818A, T85.818D, T85.818S, T85.828A, T85.828D, T85.828S, T85.838A, T85.838D, T85.838S, T85.848A, T85.848D, T85.848S, T85.858A, T85.858D, T85.858S, T85.868A, T85.868D, T85.868S, T85.898A, T85.898D, and T85.898S • Added notation to indicate D24.9, D48.60, and D49.3 were "deleted Jul. 10, 2021" **For CPT codes 15780, 15781, 15782, and 15783** • Added notation to indicate L71.9 was "deleted Jul. 10, 2021" **For CPT code 19316** • Added C84.7A, T85.818A, T85.818D, T85.818S, T85.828A, T85.828D, T85.828S, T85.838A, T85.838D, T85.838S, T85.848A, T85.848D, T85.848S, T85.858A, T85.858D, T85.858S, T85.868A, T85.868D, T85.868S, T85.898A, T85.898D, and T85.898S • Added notation to indicate D24.9, D48.60, and D49.3 were "deleted Jul. 10, 2021" **For CPT code 19318** • Added notation to indicate: ○ C44.501, C44.511, C44.521, C44.591, C50.021, C50.022, C50.121, C50.122, C50.221, C50.222, C50.321, C50.322, C50.421, C50.521, C50.522, C50.621, C50.622, C50.821, C50.822, C50.921, C50.922, C79.2, C79.81, D04.5, D05.01, D05.02, D05.11, D05.12, D05.81, D05.82, D24.1, D24.2, N60.01, N60.02, N60.11, N60.12, N60.21, N60.22, N60.31, N60.32, N60.41, N60.42, N60.81, N60.82, N60.91, N60.92, and Z42.1 were "deleted Nov. 13, 2021" ○ M25.519, M40.00, M40.03, M40.04, M40.05, M40.202, M40.203, M40.204, M40.205, M40.209, M43.6, N64.2, R29.5, and Z42.8 were "deleted Jul. 11, 2021" **For CPT codes 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, and 30468** • Added notation to indicate Q37.8 and Q37.9 were "deleted Jul. 10, 2021" **Definitions** • Added definition of: ○ American Society of Plastic Surgeons' Gynecomastia Scale • Updated definition of: ○ Abdominoplasty ○ Macromastia (Breast Hypertrophy) **Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version MPG065.09

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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 below 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.

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.

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*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.

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