Cosmetic and Reconstructive Procedures

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member, including care that may be both medically reasonable and necessary.

The Medicare Advantage medical policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and Centers of Medicare and Medicaid Services (CMS) policies and manuals, along with general CMS rules and regulations. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of a specific CMS coverage determination for a requested service, item or procedure, the health plan may apply CMS regulations, as well as their Medical Policy Manual or other applicable utilization management vendor criteria developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Some services or items may appear to be medically indicated for an individual, but may be a direct exclusion of Medicare or the member's benefit plan. Medicare and member EOCs exclude from coverage, among other things, services or procedures considered to be investigational (experimental) or cosmetic, as well as services or items considered not medically reasonable and necessary under Title XVIII of the Social Security Act, §1862(a)(1)(A). In some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services. Members, their appointed representative, or a treating provider can request coverage of a service or item by submitting a pre-service organization determination prior to services being rendered.

DESCRIPTION

Cosmetic surgery is performed to reshape normal structures of the body to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function but may also be done to approximate a normal appearance. *(Noridian LCD L37020)*

MEDICARE ADVANTAGE POLICY CRITERIA

Note: This policy is not intended to address treatment of gender dysphoria. See the *Gender Affirming Interventions for Gender Dysphoria* Medicare Advantage medical policy, Medicine, Policy No. M-153, which may be applicable.

Procedure(s):	CPT and/or HCPCS Code(s)	CMS Coverage Manuals and National Coverage Determinations (NCD)*	Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCD) and Articles*	Medical Policy Manual
Abdominoplasty **without** diastasis recti or **without** panniculectomy • *For repair of diastasis recti, see separate row below* • *For abdominoplasty **with** panniculectomy, see separate row below.*	17999 *Note, CPT code 15847 cannot be reported alone because it is an add-on code. It is the provider's responsibility to code correctly for all services rendered.*	"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." *Medicare Benefit Policy Manual, Chapter 16, §120* "Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member." *Title XVIII of the Social Security Act, Section 1862(a)(1)(P)(10)*[4] In addition to the *"Additional notes for consideration"* below, the following guidelines may be applied in the absence of specific medical necessity criteria for the services in question:	
Canthopexy/canthoplasty	21280, 21282, 67950			
CO2 laser resurfacing of lip	17999, 40799			
Collagen injection	11950-11954			
Correction of inverted nipples;	19355			
Electrolysis epilation;	17380			
Excision or surgical planing of skin of nose for rhinophyma;	30120			

Procedure(s):	CPT and/or HCPCS Code(s)	CMS Coverage Manuals and National Coverage Determinations (NCD)*	Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCD) and Articles*	Medical Policy Manual
Grafting of soft tissue or fat	15769, 15771-15774			
Laser treatment of scars (hypervascular, hypertrophic, or keloid)	17999			
Laser treatment of vascular lesions or conditions ***not otherwise addressed*** in the policy (see below for port wine stains) **Note:** A57162 states, "CPT codes 17106, 17107 and 17108 describe treatment of lesions that are usually cosmetic… clinical records should clearly document the medical necessity of such treatment and why the procedure is not cosmetic." Since specific coverage criteria are not provided, the general Medicare guidelines to the right are applicable, including documentation of functional impairment.	17106-17108			
Macrodactylia repair;	26590			
Malar augmentation;	21270			

1. If the intervention is intended to treat a functional impairment and if no other contract exclusions apply, it may be considered medically reasonable and necessary.
2. If the intervention is not intended to treat a functional impairment, the cause of the condition must be determined (i.e., accident/injury/trauma, post-treatment, congenital anomaly, disease). If the cause of the condition is included as an exception to the Medicare cosmetic surgery exclusion, then the treatment may be considered reconstructive.
3. See Cross References for other policies that address services that may be considered dental in nature, including but not limited to, mandibular and maxillary procedures and dentures.

Additional notes for consideration:
From the LCD for *Plastic Surgery* (L37020) and companion article (A57222):

- Cosmetic surgery is performed to reshape normal structures of the body, for the purpose of improving the patient's appearance and self-esteem.
- Cosmetic surgery performed purely for the purpose of enhancing one's appearance is not eligible for coverage;
- Cosmetic surgery performed to treat psychiatric or emotional problems is not covered;
- Corrective facial surgery will be considered cosmetic rather than reconstructive when there is no functional impairment present;

Procedure(s):	CPT and/or HCPCS Code(s)	CMS Coverage Manuals and National Coverage Determinations (NCD)*	Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCD) and Articles*	Medical Policy Manual
Otoplasty, protruding ear, with or without size reduction;	69300	• If a noncovered 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 surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function but may also be done to approximate a normal appearance. • Surgery to correct congenital defects, developmental abnormalities, trauma, infections, tumors, or disease may be covered when the surgery is considered reconstructive in nature.		
Plastic operation on penis to correct angulation;	54360			
Punch graft hair transplant	15775, 15776			
Reconstruction of mandible or maxilla; *(See Cross References for other policies addressing Medicare coverage of dental services)*	21244-21246, 21248, 21249			
Reduction of masseter muscle and bone;	21295, 21296			
Reduction of the forehead;	21137-21139			
Revision of tracheostomy scar;	31830			
Suture of tongue to lip for micrognathia;	41510			
Tattooing to correct color defects of skin;	11920-11922			
Umbilectomy, omphalectomy, excision of umbilicus	49250			

Procedure(s):	CPT and/or HCPCS Code(s)	CMS Coverage Manuals and National Coverage Determinations (NCD)*	Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCD) and Articles*	Medical Policy Manual
Abdominal Lipectomy, Panniculectomy (with or without abdominoplasty), and Suction-Assisted Lipectomy	15830, 15847, 15876-15879		Plastic Surgery (L37020)[1] *(Companion article A57222 can be accessed directly from the LCD)*	
Chemical peel	15788, 15789, 15792, 15793	For the treatment of actinic keratosis (AKs): 250.4		For all other indications: *Chemical Peels, Surgery, Policy No. 12.50 (see "Note" below)*
Dental services/procedures	21244-21246, 21248, 21249	See Cross References for other policies addressing Medicare coverage of dental services.		
Dermabrasion, all indications	15780-15783, 15786, 15787	For the treatment of actinic keratosis (AKs): 250.4	Plastic Surgery (L37020) *(Companion article A57222 can be accessed directly from the LCD)*	
Dermal injections for the treatment of facial lipodystrophy syndrome	C9800, G0429	250.5		
Excision of excessive skin and subcutaneous tissue (includes lipectomy) ***for other***	15832-15839		Plastic Surgery (L37020) *(Companion article A57222 can be*	

Procedure(s):	CPT and/or HCPCS Code(s)	CMS Coverage Manuals and National Coverage Determinations (NCD)*	Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCD) and Articles*	Medical Policy Manual
than the abdomen and eyelids;			*accessed directly from the LCD)*	
Mastectomy for Gynecomastia	19300		Plastic Surgery (L37020) *(Companion article A57222 does not provide coding guidance for mastectomy for gynecomastia)*	
Reconstructive Breast Surgery/Mastopexy, and Management of Breast Implants		See Cross References for policy addressing Medicare coverage of reconstructive breast procedures and implants not otherwise addressed in this policy		
Reduction Mammaplasty (Mammoplasty)		See Cross References for policy addressing Medicare coverage of reduction mammaplasty.		
Revision of or Complications as a result of Prior Cosmetic Procedure		Medicare Benefit Policy Manual, Chapter 16 *See Section 180 in the following link:* §180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare	(See also *Plastic Surgery (L37020)*: *"Benefits may be provided for complications arising from cosmetic surgery. Such complications include infection, hemorrhage, or other*	

Procedure(s):	CPT and/or HCPCS Code(s)	CMS Coverage Manuals and National Coverage Determinations (NCD)*	Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCD) and Articles*	Medical Policy Manual
			serious documented medical complication."	
Rhinoplasty and other nasal surgery	30400, 30410, 30420, 30430, 30435, 30450		Plastic Surgery (L37020) *(Companion article A57222 can be accessed directly from the LCD)*	
Rhytidectomy	15824-15826, 15828, 15829	For ***correction of "Moon Face":*** 140.4	For ***all other indications:*** Plastic Surgery (L37020) *(Companion article A57222 does not provide coding guidance for rhytidectomy)*	
Varicose Vein Treatment		See Cross References for policy addressing Medicare coverage of varicose vein treatments, including removal of telangiectasias (spider veins).		
At this time, specific Medicare coverage guidance is not available in the health plan's service area for the following services. Therefore, the health plan's medical policy is applicable.				
Microdermabrasion, all indications	15780-15783, 15786, 15787			*Dermabrasion and Microdermabrasion, Surgery, Policy No. 12.04 (see "Note" below)*

Procedure(s):	CPT and/or HCPCS Code(s)	CMS Coverage Manuals and National Coverage Determinations (NCD)*	Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCD) and Articles*	Medical Policy Manual
Pectus Excavatum	21740, 21742, 21743			*Pectus Excavatum and Carinatum Treatment,* Surgery, *Policy No. 12.02 (see "Note" below)*
Port Wine Stain Laser Treatment	17106-17108	*A57162 states, "CPT codes 17106, 17107 and 17108 describe treatment of lesions that are usually cosmetic… clinical records should clearly document the medical necessity of such treatment and why the procedure is not cosmetic." However, the article does not provide criteria specific to port wine stains to determine coverage, so the health plan coverage criteria are applied.*		*Laser Treatment for Port Wine Stains, Surgery, Policy No. 12.34 (see "Note" below)*
Surgical repair of diastasis recti	Includes but may not be limited to 17999			*Ventral (Including Incisional) Hernia Repair, Surgery, Policy No. 12.03 (see "Note" below)*

NOTE: According to Title XVIII of the Social Security Act, §1862(a)(1)(A), only medically reasonable and necessary services are covered by Medicare. In the absence of a NCD, LCD, or other coverage guideline, CMS guidelines allow a Medicare Advantage Organization (MAO) to make coverage determinations, applying an ***objective, evidence-based process, based on authoritative evidence***. (*Medicare IOM Pub. No. 100-16, Ch. 4, §90.5*). The Medicare Advantage Medical Policy - Medicine Policy No. M-149 - provides further details regarding the plan's evidence-assessment process (see Cross References).

POLICY GUIDELINES

REQUIRED DOCUMENTATION

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome:

- Requested treatment, symptoms experienced, and history of condition being treated;
- Documentation regarding the functional impairment that has been caused by the condition and that requires repair; and
- Documentation of circumstances which caused the condition (e.g., congenital, post-surgery, accident, injury, etc., as applicable).

CROSS REFERENCES

Dental Services, Allied Health, Policy No. M-35
Investigational (Experimental) Services, New and Emerging Medical Technologies and Procedures, and Other Non-Covered Services, Medicine, Policy No. M-149
Gender Affirming Interventions for Gender Dysphoria, Medicine, Policy No. M-153
Blepharoplasty, Eyelid Surgery, and Brow Lift, Surgery, Policy No. M-12.05
Reconstructive Breast Surgery, Mastopexy, and Management of Breast Implants, Surgery, Policy No. M-40
Reduction Mammaplasty (Mammoplasty), Surgery, Policy No. M-60
Varicose Vein Treatment, Surgery, Policy No. M-104
Orthognathic Surgery, Surgery, Policy No. M-137
Adipose-derived Stem Cell Enrichment in Autologous Fat Grafting to the Breast, Surgery, Policy No. M-182
Surgical Treatments for Lymphedema and Lipedema, Surgery, Policy No. M-220

REFERENCES

1. Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §120 – Cosmetic Surgery
2. Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare
3. Title XVIII of the Social Security Act, Section 1862(a)(1)(P)(10)

CODING

NOTE: CPT code 69090 is a Medicare Status "N" code, and therefore, is non-covered for Medicare and Medicare Advantage. In addition, CPT codes 17106-17108 are used for the destruction of vascular proliferative lesions only. If the treatment does not destroy the lesion, or if a lesion is not considered a "vascular proliferative lesion" (e.g., hypervascular, hypertrophic, or keloid scars), then the treatment should not be reported using these codes. Unlisted code 17999 *(Unlisted procedure, skin, mucous membrane and subcutaneous tissue)* should be reported instead.

Codes	Number	Description
CPT	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
	11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
	11951	; 1.1 to 5.0 cc
	11952	; 5.1 to 10.0 cc
	11954	; over 10.0 cc
	15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, 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	; 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	; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
	15775	Punch graft for hair transplant; 1 to 15 punch grafts
	15776	; more than 15 punch grafts
	15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
	15781	Dermabrasion; segmental, face
	15782	Dermabrasion; regional, other than face
	15783	Dermabrasion; superficial, any site (eg, tattoo removal)
	15786	Abrasion; single lesion (eg, keratosis, scar)
	15787	Abrasion; each additional four lesions or less
	15788	Chemical peel, facial; epidermal
	15789	Chemical peel; facial; dermal
	15792	Chemical peel; nonfacial; epidermal
	15793	Chemical peel; nonfacial; dermal
	~~15819~~	~~Cervicoplasty~~ (Deleted 01/01/2025)
	15824	Rhytidectomy; forehead
	15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
	15826	Rhytidectomy; glabellar frown lines
	15828	Rhytidectomy; cheek, chin and neck
	15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
	15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
	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
	15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication)
	15876	Suction assisted lipectomy; head and neck
	15877	Suction assisted lipectomy; trunk
	15878	Suction assisted lipectomy; upper extremity
	15879	Suction assisted lipectomy; lower extremity
	17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm
	17107	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq cm
	17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50 sq cm
	17360	Chemical exfoliation for acne (eg, acne paste, acid)
	17380	Electrolysis epilation, each 30 minutes
	17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
	19300	Mastectomy for gynecomastia
	19355	Correction of inverted nipples
	21137	Reduction forehead; contouring only
	21138	Reduction forehead; contouring and application of contouring material or bone graft (includes obtaining autograft)
	21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
	21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
	21245	Reconstruction of mandible, or maxilla, subperiosteal implant; partial
	21246	Reconstruction of mandible, or maxilla, subperiosteal implant; complete
	21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
	21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete
	21270	Malar augmentation, prosthetic material
	21280	Medial canthopexy
	21282	Lateral canthopexy
	21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach

	21296	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach
	21740	Reconstructive repair of pectus excavatum or carinatum; open
	21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
	21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy
	26590	Repair macrodactylia, each digit
	30120	Excision or surgical planing of skin of nose for rhinophyma
	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
	30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
	30420	Rhinoplasty, primary; including major septal repair
	30430	Rhinoplasty secondary; minor revision (small amount of nasal tip work)
	30435	Rhinoplasty secondary; intermediate revision (bony work with osteotomies)
	30450	Rhinoplasty secondary; major revision (nasal tip work and osteotomies)
	31830	Revision of tracheostomy scar
	40799	Unlisted procedure, lips
	41510	Suture of tongue to lip for micrognathia (Douglas type procedure)
	49250	Umbilectomy, omphalectomy, excision of umbilicus
	54360	Plastic operation on penis to correct angulation
	67950	Canthoplasty (reconstruction of canthus)
	67999	Unlisted procedure, eyelids
	69090	Ear piercing *(Non-covered by Medicare)*
	69300	Otoplasty, protruding ear, with or without size reduction
HCPCS	G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)

***IMPORTANT NOTE:** Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan's web control as these sites are not maintained by the health plan.*