

Medicare Medical Policy

Cosmetic and Reconstructive Procedures

MEDICARE MEDICAL POLICY NUMBER: 232

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INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Notes:

- Member contracts (Evidence of Coverage, or EOCs) may have specific language regarding covered reconstructive services and excluded cosmetic procedures. Contract language takes precedence over this medical policy.
- Please see [Policy Cross References](#) below for separate policies which may apply to other potentially cosmetic or reconstructive procedures. This includes, but is not limited to:
 - Services and procedures related to the treatment of gender dysphoria.
 - Breast reconstruction following a mastectomy.
 - Varicose vein treatments.

| Service | Medicare Guidelines |
|---|--|
| <i>Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome</i> | National Coverage Determination (NCD): Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (250.5) |
| <i>Plastic Surgery to Correct "Moon Face"</i> | NCD: Plastic Surgery to Correct "Moon Face" (140.4) |
| <i>Chemical Peels</i> | As a treatment of actinic keratoses (AKs): <ul style="list-style-type: none"> • NCD: Treatment of Actinic Keratosis (250.4) For all other indications: <ul style="list-style-type: none"> • See separate row for Company medical policy criteria below |
| <i>Plastic Surgery</i> <ul style="list-style-type: none"> • <i>Dermabrasion</i> • <i>Rhytidectomy</i> • <i>Cosmetic nasal surgery</i> • <i>Reconstructive nasal surgery</i> • <i>Mastectomy for gynecomastia</i> | LCD: Plastic Surgery (L37020) <p>NOTE: Other services included in this LCD are addressed in other PHP medical policies. Please see Policy Cross References for other potentially applicable policies.</p> |

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| <p><i>Benign Skin Lesion Removal</i></p> <ul style="list-style-type: none"> • <i>Seborrheic keratoses</i> • <i>Skin tags</i> • <i>Milia</i> • <i>Molluscum contagiosum</i> • <i>Sebaceous (epidermoid) cysts</i> • <i>Moles (nevi)</i> • <i>Acquired hyperkeratosis (keratoderma)</i> • <i>Viral warts (excluding condyloma acuminatum)</i> | <p>LCD: Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (L33979)</p> <p>NOTE: This LCD does not apply to: routine foot care or the treatment of other skin lesions, e.g., actinic keratosis (AK), Mohs, ulcers, abscess, malignancies, dermatoses or psoriasis.</p> |
| <p><i>Ear Piercing (CPT 69090) and Body Piercing</i></p> | <p>Ear and body piercing are cosmetic and not covered benefits.</p> <p>NON-COVERAGE POSITION SUMMARY: CPT code 69090 for ear piercing is a Medicare Status “N” code, which is defined as “Non-covered Services.” Body piercing does not meet Medicare’s medically necessary coverage requirements. Both procedures are statutorily excluded based the <i>Social Security Act, Section 1862(a)(1)(A)</i>.</p> |
| <p><i>Penile Prosthesis Implant (CPT 54400, 54401, 54405, and 54410 and HCPCS C1813 and C2622)</i></p> | <p>Penile prosthesis implantation to treat impotence caused by congenital defect, illness, trauma, or following other surgical procedures may be considered medically necessary:</p> <ul style="list-style-type: none"> • NCD for Diagnosis and Treatment of Impotence (230.4) <p>Penile prosthesis implantation performed to improve appearance or enhance sexual performance:</p> <ul style="list-style-type: none"> • See separate row for Company medical policy criteria below |
| <p><i>Treatment of complications resulting from a prior cosmetic procedure</i></p> | <p>Complications arising from cosmetic surgery may be considered medically necessary in some situations (see Medicare references below). Examples include, but may not be limited to, infection, hemorrhage, or other serious documented medical complication.</p> <ul style="list-style-type: none"> • 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 • LCD: Plastic Surgery (L37020) |
| <p><i>Potentially cosmetic procedures addressed in separate plan policies</i></p> <p><i>See Cross References below</i></p> | <ul style="list-style-type: none"> • Abdominoplasty, lipectomy and panniculectomy • Botulinum Toxin (Botox) treatment • Brachioplasty (arm lift) to remove excess skin • For all breast-related surgeries, including breast tattooing, please first refer to the separate medical policies related to breast reconstruction or reduction mammoplasty procedures. |

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| | <ul style="list-style-type: none"> • Blepharoplasty, blepharoptosis repair and brow lift • Cleft lip and/or cleft palate repair and other orthognathic procedures • Hemangioma (e.g., Port wine stain) and other vascular lesion laser treatment • Sclerotherapy or other treatments of superficial varicosities (i.e., telangiectasias/spider veins and reticular/feeder veins) and other treatments of varicose veins • Services and procedures related to the treatment of gender dysphoria • Liposuction for lipedema |
| <p><i>Potentially cosmetic procedures NOT OTHERWISE ADDRESSED</i></p> | <p>For any procedure not addressed in the rows above, <u>or</u> in a separate medical policy, <u>or</u> by using Commercial medical policy criteria (below), apply the following Medicare cosmetic vs. reconstructive guidance.</p> <ol style="list-style-type: none"> I. Cosmetic procedures are not covered benefits: Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §120 – Cosmetic Surgery¹ II. Reconstructive procedures may be medically necessary: Local Coverage Determination (LCD): Plastic Surgery (L37020). <p>To determine if a procedure is considered cosmetic or reconstructive, the following must be considered:</p> <ol style="list-style-type: none"> 1. If a direct member contract exclusion applies, deny the service not a covered benefit. 2. If the intervention is intended to treat a functional impairment, the procedure may be considered medically necessary as a reconstructive procedure. 3. 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 medically necessary. (Examples include, but are not limited to, wound repair following removal of skin lesions or skin biopsy.) |
| <p><i>Services which use Commercial criteria for guidance to determine if cosmetic or reconstructive</i></p> | <p>Company medical policy for Cosmetic and Reconstructive Surgery</p> <ol style="list-style-type: none"> I. The list of services below may be considered medically necessary for Medicare when the Company medical policy criteria are met. II. The listed services below are considered cosmetic for Medicare when the Company medical policy criteria are not met <u>or</u> when a service is deemed “cosmetic” by the Company policy. <u>See Policy Guidelines below.</u> |

- Chemical exfoliation or peels for treatment of conditions other than AKs.
- Cryotherapy (CO2 slush, liquid N2) for acne.
- Collagen injections or implants.
- Ear repair/reconstruction (including otoplasty).
- Frown line removal, including but not limited to the excision or correction of glabellar frown lines or forehead lift (cosmetic foreheadplasty).
- Hair removal (e.g., laser, electrolysis).
- Hair transplant/hairplasty.
- Injections of compounds to treat skin wrinkles, including but not limited to gel-particle hyaluronic acid (e.g., Restylane, Perlane), calcium hydroxylapatite (e.g., Radiesse) and collagen (e.g., Zyderm).
- Keloid or scar surgical repair/revision.
- Laser skin resurfacing, for all indications including but not limited to acne scarring and wrinkles.
- Mentoplasty/genioplasty (chin) done for a receding chin or to reduce a prominent chin.
- Neck tuck/lift (Platysmaplasty or Submental Lipectomy).
- Pectus excavatum repair (open or Nuss procedures only)
- Penile procedures, including but not limited to phalloplasty and fat injections, for reasons other than impotence treatment.
- Tattoo removal or follow up.
- Vaginal procedures including rejuvenation/vaginal tightening, designer vaginoplasty, revirgination, G-spot amplification for all indications.
- Vaginal procedures including labia surgery/reshaping/reduction (labiaplasty) when intended to improve the appearance or enhance sexual performance.

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. (*Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021*)

POLICY CROSS REFERENCES

MEDICAL POLICY

- [Breast Surgery: Reduction Mammoplasty, Reconstructive Surgery and Implant Management](#), MP523
- [Eye: Blepharoplasty, Blepharoptosis Repair, and Brow Lift](#), MP225

- [Gender Affirming Surgical Interventions](#), MP32
- [Hemangioma and Vascular Malformation Laser Treatment](#), MP62
- [Liposuction for Lipedema](#), MP351
- [Orthognathic Surgery](#), MP160
- [Rhinoplasty](#), MP247
- [Surgical Treatments for Lymphedema](#), MP341
- [Surgical Treatment for Skin Redundancy](#), MP259
- [Varicose Veins](#), MP187

PHARMACY POLICY

- [Botulinum Toxin \(Medicare Only\)](#), ORPTCNEU030.0821

The full Company portfolio of Medicare Medical Policies is available online and can be [accessed here](#).

POLICY GUIDELINES

COSMETIC SURGERY

According to the Medicare Benefit Policy Manual, Chapter 16, §120:

“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.”

Therefore, under *Title XVIII of the Social Security Act, Section 1862(a)(1)(P)(10)(4)*, cosmetic procedures or services are excluded from Medicare coverage:

“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.”

RECONSTRUCTIVE SURGERY

Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. While it is generally performed to improve function, it may also be done to approximate a normal appearance. (*Noridian LCD L37020*)

MEDICARE COVERAGE

In order to determine if coverage is available for a procedure, review may be required to determine if the procedure is cosmetic or reconstructive in nature.

Medicare and Medical Necessity

For Medicare, only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*.

The Company policy for *PHA Medicare Medical Policy Development and Application (MP50)* provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.) which addresses the medical necessity of a given medical service, Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. (*Medicare Managed Care Manual, Ch. 4, §90.5*)

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

GENERAL

See associated local coverage articles (LCAs), when available, for relevant coding and billing guidance:

- LCA: Billing and Coding: Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) ([A57162](#))

EAR PIERCING

The *National Physician Fee Schedule Relative Value File (NPF SRVF)*, which is published by the Centers for Medicare and Medicaid Services (CMS)², indicates CPT code 69090 has been assigned a Status Indicator of "N," which is defined as "Non-covered Services." This is a statutorily excluded service based on Medicare requirements for medically reasonable and necessary services, as defined by the *Social Security Act, Section 1862(a)(1)(A)*.

LIMITED COVERAGE

Some of the codes in this policy do not require routine review or prior authorization, but coverage may be limited to select indications.

Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)

The following ICD-10-CM diagnosis codes must be included on the claim:

- B20 Human Immunodeficiency Virus (HIV) disease; **and**
- E88.1 Lipodystrophy, not elsewhere classified

Benign Skin Lesion Removal

Benign skin lesions include, but may not be limited to, skin tags, moles, warts, etc. While the codes which represent these services do not require routine review for medical necessity, they may be subject to utilization audit. Benign skin lesion removal may only be considered reconstructive and medically necessary when the criteria found in the LCD L33979 (see criteria table above) are met.

Dermabrasion (CPT codes 15780, 15781, 15782, and 15783)

Dermabrasion codes (CPT codes 15780-15783) are only considered reconstructive and medically necessary when billed with the diagnosis codes included in the Medicare Local Coverage Article (LCA) for Plastic Surgery. Please see Group 1 ICD-10 Codes in the Plastic Surgery LCA ([A57222](#)) for the complete list of diagnosis codes.

| CODES* | | |
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| Note: | | |
| <ul style="list-style-type: none">• Some codes may require prior authorization for all indications, while other codes may be considered cosmetic and non-covered for all indications.• Still other codes may only be considered medically necessary when billed with diagnosis codes F64.0, F64.1, F64.8, or F64.9, but are considered cosmetic and non-covered for all other indications.• Please refer to the Company non-covered and prior authorization lists for additional information | | |
| CPT | 10040 | Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules) |
| | 11200 | Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions |
| | 11201 | Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (list separately in addition to code for primary procedure) |
| | 11300 | Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less |
| | 11301 | Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm |
| | 11302 | Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm |
| | 11303 | Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm |
| | 11305 | Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less |

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| 11306 | Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm |
| 11307 | Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm |
| 11308 | Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm |
| 11310 | Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less |
| 11311 | Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm |
| 11312 | Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm |
| 11313 | Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm |
| 11400 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less |
| 11401 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm |
| 11402 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm |
| 11403 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm |
| 11404 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm |
| 11406 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm |
| 11420 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less |
| 11421 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm |
| 11422 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm |
| 11423 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm |
| 11424 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm |
| 11426 | Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm |
| 11440 | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less |
| 11441 | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm |
| 11442 | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm |
| 11443 | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm |

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| 11444 | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm |
| 11446 | Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm |
| 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) |
| 11950 | Subcutaneous injection of filling material (eg, collagen); 1 cc or less |
| 11951 | Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc |
| 11952 | Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc |
| 11954 | Subcutaneous injection of filling material (eg, collagen); over 10.0 cc |
| 15769 | Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia) |
| 15775 | Punch graft for hair transplant; 1 to 15 punch grafts |
| 15776 | Punch graft for hair transplant; 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 (e.g. keratosis, scar) |
| 15787 | Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure) |
| 15788 | Chemical peel, facial; epidermal |
| 15789 | Chemical peel, facial; dermal |
| 15792 | Chemical peel, nonfacial; epidermal |
| 15793 | Chemical peel, nonfacial; dermal |
| 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 |
| 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 |

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| | 15847 | Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (list separately in addition to code for primary procedure) |
| | 15876 | Suction assisted lipectomy; head and neck |
| | 15877 | Suction assisted lipectomy; trunk |
| | 15878 | Suction assisted lipectomy; upper extremity |
| | 15879 | Suction assisted lipectomy; lower extremity |
| | 17110 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions |
| | 17111 | Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions |
| | 17340 | Cryotherapy (CO2 slush, liquid N2) for acne |
| | 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 |
| | 21120 | Genioplasty; augmentation (autograft, allograft, prosthetic material) |
| | 21121 | Genioplasty; sliding osteotomy, single piece |
| | 21122 | Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin) |
| | 21123 | Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts) |
| | 21137 | Reduction forehead; contouring only |
| | 21270 | Malar augmentation, prosthetic material |
| | 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 |
| | 40799 | Unlisted procedure, lips |
| | 54400 | Insertion of penile prosthesis; non-inflatable (semi-rigid) |
| | 54401 | Insertion of penile prosthesis; inflatable (self-contained) |
| | 54405 | Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir |
| | 54410 | Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session |
| | 54440 | Plastic operation on penis for injury |
| | 56800 | Plastic repair of introitus |
| | 57291 | Construction of artificial vagina, without graft |
| | 57292 | Construction of artificial vagina, with graft |
| | 67999 | Unlisted procedure, eyelids |
| | 69399 | Unlisted procedure, external ear |
| | 96999 | Unlisted special dermatological service or procedure |
| HCPCS | C1813 | Prosthesis, penile, inflatable |
| | C2622 | Prosthesis, penile, non-inflatable |
| | G0429 | Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome |
| | Q2026 | Injection, Radiesse, 0.1 ml |

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| Q2028 | Injection, Sculptra, 0.5 mg |
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***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, “presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare.” The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. (*Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician’s Fee Schedule, A. Physician’s Services*)
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company [Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website](#) for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. *Title XVIII of the Social Security Act, Section 1862(a)(1)(P)(10)(4)*
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POLICY REVISION HISTORY

| DATE | REVISION SUMMARY |
|---------|--|
| 10/2022 | Annual review (converted to new format 2/2023) |