Medicare Medical Policy

Cosmetic and Reconstructive Procedures

MEDICARE MEDICAL POLICY NUMBER: 232

Effective Date: 6/1/2025

Last Review Date: 3/2025

Next Annual Review: 8/2025

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, and Providence Plan Partners 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
Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome	National Coverage Determination (NCD): Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (250.5)
Plastic Surgery to Correct "Moon Face"	NCD: Plastic Surgery to Correct "Moon Face" (140.4)
Chemical Peels	As a treatment of actinic keratoses (AKs): • NCD: Treatment of Actinic Keratosis (250.4) For all other indications: • See separate row for Company medical policy criteria below
Acne Surgery (CPT 10040)	When performed as a wound debridement: • Local Coverage Determination (LCD): Wound and Ulcer Care (L38904) When performed on benign skin lesions: • LCD: Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (L33979)

	NOTES: CPT 10040 (acne surgery) is used for procedures such as marsupialization, and the opening or removal of cysts, pustules, comedones, and milia. Therefore, while CPT 10040 is not included in the companion billing and coding article, if acne surgery (CPT 10040) is performed to report any procedure addressed by this "benign skin lesion removal" LCD, then the LCD criteria apply. Specifically, the LCD states, "Removal of benign skin lesions that do not pose a threat to health or function is considered cosmetic and as such is not covered by the Medicare program." For any other indication: • See Company policy criteria below
Plastic Surgery • *Dermabrasion* • *Rhytidectomy* • *Cosmetic nasal surgery* • *Reconstructive nasal surgery* • *Mastectomy for gynecomastia*	LCD: Plastic Surgery (L37020) **NOTE:** Other services included in this LCD are addressed in other PHP medical policies. Please see Policy Cross References for other potentially applicable policies.
Skin Tag Removal (CPT 11200, 11201)	LCD: Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (L33979)
Ear Piercing (CPT 69090) and Body Piercing	Ear and body piercing are **cosmetic and not covered benefits**. **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 *Social Security Act, Section 1862(a)(1)(A)*.
Penile Prosthesis Implant (CPT 54400, 54401, 54405, and 54410 and HCPCS C1813 and C2622)	Penile prosthesis implantation to treat impotence caused by congenital defect, illness, trauma, or following other surgical procedures may be considered **medically necessary**: • NCD for Diagnosis and Treatment of Impotence (230.4) Penile prosthesis implantation performed to improve appearance or enhance sexual performance: • See separate row for Company medical policy criteria below
Treatment of complications resulting from a prior cosmetic procedure	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.

	• 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)
Potentially cosmetic procedures addressed in separate plan policies *See Cross References below*	• 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. • 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
Potentially cosmetic procedures NOT OTHERWISE ADDRESSED	For any procedure **not** addressed in the rows above, or in a separate medical policy, or by using Commercial medical policy criteria (below), apply the following Medicare cosmetic vs. reconstructive guidance. I. Cosmetic procedures are not covered benefits: Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §120 – Cosmetic Surgery[1] II. Reconstructive procedures may be medically necessary: Local Coverage Determination (LCD): Plastic Surgery (L37020). To determine if a procedure is considered cosmetic or reconstructive, the following must be considered: 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.)
Medicare Coverage Criteria: "MA organizations may create publicly accessible internal coverage criteria… when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs." *(§ 422.101(b)(6) – see Policy Guidelines below)* • **Medicare Coverage Manuals:** Medicare does not have criteria for specific cosmetic or reconstructive procedures in a coverage manual. **However, broad coverage requirements are provided by Medicare for cosmetic surgery in general.** Specifically, Medicare requires diagnostic laboratory tests be ordered by a provider who is treating the member for a specific medical problem and who will promptly use the test results in the direct management of that specific medical problem.[1,2] These coverage criteria are considered "not fully established" under CFR § 422.101(6)(i)(A) as additional criteria are needed to interpret or supplement these general coverage provisions in order to determine medical necessity consistently. • **National Coverage Determination (NCD):** With the exception of services noted above addressed by an NCD, there are no NCDs for cosmetic procedures. • **Noridian J-F Local Coverage Determination (LCD)/Local Coverage Article (LCA):** As of the most recent policy review, several Medicare Administrative Contractors (MACs) have LCDs for various cosmetic or reconstructive procedures; however, not all possible procedures are addressed in these LCDs. • Therefore, in the absence of established Medicare coverage criteria in a manual, NCD, LCD, or other regulatory guidance for the plan's service area, Company criteria below are applied for medical necessity decision-making. Medicare statutes and regulation state cosmetic procedures are statutorily excluded, but that reconstructive procedures may be considered medically necessary. However, additional criteria are needed to supplement the Medicare criteria are being used in order to determine medical necessity consistently. These additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services. Specifically, current, widely-used treatment guidelines developed by organizations representing clinical medical specialties is evaluated to determine whether or not a condition may be considered medically necessary, rather than cosmetic. • ***NOTE:*** *The summary of evidence, as well as the list of citations/references used in the development of the Company's internal coverage criteria, are publicly available and can be found using the Company medical policy link below [CFR § 422.101(6)(ii)(A) and (B)].*	
Services which use internal coverage (Company) criteria for guidance to determine if cosmetic or reconstructive	Company medical policy for Cosmetic and Reconstructive Surgery 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 ***or*** when a service is deemed "cosmetic" by the Company policy. *See Policy Guidelines below.*

	• Acne surgery (CPT 10040; for indications not addressed above) • Chemical exfoliation or peels for treatment of conditions other than AKs (CPT 17360). • Cryotherapy (CO2 slush, liquid N2) for acne (CPT 17340). • 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

- Benign Skin Lesions, MP423
- Breast Reconstructive Surgery, Implant Management, and Reduction Mammoplasty, MP523
- 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)*. MA organizations (MAOs) make medical necessity determinations based on coverage and benefit criteria, current standards of care, the member's unique personal medical history (e.g., diagnoses, conditions, functional status, co-morbidities, etc.), physician recommendations, and clinical notes, as well as involvement of a plan medical director, where appropriate. *(§ 422.101(c)(1))*

In addition:

> "MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question." *(§ 422.101(b)(6) and Medicare Managed Care Manual, Ch. 4, §90.5)*

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.

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)

Many services do not have a specific CPT code to use and therefore may be reported with an unlisted code such as 17999, 40799, 67999, 69399, or 96999 (not an all-inclusive list). Examples include, but may not be limited to, the following:

- Some laser resurfacing procedures may be reported using an unlisted code such as 17999 or 40799.
- Some laser hair removal procedures may be reported with CPT 17999.
- CPT codes 17106-17108 are used for the destruction of vascular proliferative lesions, which are addressed in a separate Medicare Advantage medical policy. If a lesion is not considered a "vascular proliferative lesion" (e.g., hypertrophic or keloid scars, etc.), the treatment should not be reported using these codes and either an unlisted code (e.g., 17999) or Category III code 0479T/0480T (if appropriate) would be reported instead.
- An unlisted code such as 17999 may also be necessary to report for some gender dysphoria/incongruence-related procedures. See the separate medical policy ***Gender Affirming Surgical Interventions*** for these indications.

EAR PIERCING

The *National Physician Fee Schedule Relative Value File (NPFSRVF)*, 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*

Note:

- 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)
	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
	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
	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
	Q2028	Injection, Sculptra, 0.5 mg

***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)*
2. Medicare Physician Fee Schedule (PFS) Relative Value Files; Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files
3. Centers for Medicare & Medicaid Services. Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual. Publication # 100-4. Chapter 32 – Billing Requirements for Special Services. §260 - Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS); Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
10/2022	Annual review (converted to new format 2/2023)
9/2023	Annual review; no changes
9/2024	Annual review; no changes
11/2024	Interim update; update criteria for acne surgery
6/2025	Interim update; moved benign skin lesion services to new policy