## Contractor Information

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<th>CONTRACTOR NAME</th>
<th>CONTRACT TYPE</th>
<th>CONTRACT NUMBER</th>
<th>JURISDICTION</th>
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CONTRACTOR NAME | CONTRACT TYPE | CONTRACT NUMBER | JURISDICTION | STATE(S)  
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Novitas Solutions, Inc. | A and B MAC | 12901 - MAC A | J - L | District of Columbia Delaware Maryland New Jersey Pennsylvania

**LCD Information**

**Document Information**

**LCD ID**  
L35090

**Original ICD-9 LCD ID**  
L32763

**LCD Title**  
Cosmetic and Reconstructive Surgery

**Proposed LCD in Comment Period**  
N/A

**Source Proposed LCD**  
DL35090

**Original Effective Date**  
For services performed on or after 10/01/2015

**Revision Effective Date**  
For services performed on or after 05/30/2019

**Revision Ending Date**  
N/A

**Retirement Date**  
N/A

**Notice Period Start Date**  
11/05/2015

**Notice Period End Date**  
12/30/2015

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**CMS National Coverage Policy**

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for cosmetic reconstructive surgery services. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for cosmetic reconstructive surgery services and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies may be found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

**IOM Citations:**

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16: Section 10, General Exclusions from Coverage, Section 120 Cosmetic Surgery and Section 180 Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare.
- CMS IOM Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1,
  - Part 2, Section 140.2, Breast Reconstruction Following Mastectomy and Section 140.4, Plastic Surgery to Correct “Moon Face”.
  - Part 4, Section 250.5. Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS).
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 13, Section 13.5.4 Reasonable and Necessary Provision in an LCD.

**Social Security References:**

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1862 (a)(10). This section excludes Cosmetic Surgery.
- Title XVIII of the Social Security Act, Section 1833 (e). This section states that no payment shall be made to any provider for any claims that lack the necessary information to process the claim.
Coverage Guidance
Coverage Indications, Limitations, and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

History/Background and/or General Information

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

Reconstructive Surgery
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 or symmetric appearance.

Cosmetic Surgery
Cosmetic surgery is performed to reshape normal structures of the body to improve the patient's appearance and self-esteem. Please refer to CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 16: Section 120 for detailed information.

However, surgery to correct congenital defects, developmental abnormalities, trauma, infections, tumors or disease may be covered because the surgery is considered reconstructive in nature.

Corrective facial surgery will be considered cosmetic rather than reconstructive 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.

Treatment of complications arising from cosmetic surgery will be considered reasonable and necessary as long as infection, hemorrhage or other serious documented medical complication occurs and the beneficiary has been officially discharged from the facility.

Covered Indications

The following procedures may be considered reasonable and necessary when performed for the reasons indicated:
1. Dermabrasion Coverage will be provided when correcting defects resulting from traumatic injury, surgery or disease.

Dermabrasion, segmental, face in conjunction with antimicrobial therapy is covered for the treatment of rhinophyma.

2. Abdominal Lipectomy/Panniculectomy
Abdominal Lipectomy/Panniculectomy is surgical removal of excessive fat and skin from the abdomen. When surgery is performed to alleviate such complicating factors as inability to walk normally, chronic pain, ulceration created by the abdominal skin fold, or intertrigal dermatitis, such surgery is considered reconstructive. Preoperative photographs may be required to support justification and should be supplied upon request.

Panniculectomy will be considered medically necessary when the pannus or panniculus hangs below the level of the pubis, and the medical records document that the panniculus causes chronic intertrigo (dermatitis occurring on opposed surfaces of the skin, skin irritation, infection or chafing) that consistently recurs over three months while receiving appropriate medical therapy, or remains refractory to appropriate medical therapy over a period of three months.

Note: If the procedure is being performed following significant weight loss, in addition to meeting the criteria noted above, there should be evidence that the individual has maintained a stable weight for at least six months. If the weight loss is the result of bariatric surgery, abdominoplasty/panniculectomy should not be performed until at least 24 months after bariatric surgery and only when weight has been stable for at least the most recent six months and infection and inflammation has continued.

3. Reconstructive Breast Surgery: Removal of Breast Implants
For a patient who has had an implant(s) placed for reconstructive or cosmetic purposes, Medicare considers treatment of any one or more of the following conditions to be medically necessary:

- Broken or failed implant.
- Infection.
- Implant extrusion.
- Siliconoma or granuloma.
- Interference with diagnosis of breast cancer.
- Painful capsular contracture with disfigurement.

Reconstruction or Replacement of an implant requiring removal for any of the above indications that was originally placed for reconstruction of a traumatic or surgically created breast deficit will be covered as medically necessary.

4. Reduction Mammoplasty
Macromastia (breast hypertrophy) is an increase in the volume and weight of breast tissue relative to the general body habitus. Breast hypertrophy may adversely affect other body systems (e.g., musculoskeletal, respiratory, integumentary). Unilateral hypertrophy may result in symptoms following contralateral mastectomy.
**Reduction mammoplasty** is performed:

- To reduce the size of the breasts and help ameliorate symptoms caused by hypertrophy.
- To reduce the size of a normal breast to bring it into symmetry with a breast reconstructed after cancer surgery.
- After full breast evaluation including recent mammogram (over the age 35).
- With histologic pathology performed on all breast tissue resected.

Medicare medical necessity for reduction mammoplasty is limited to circumstances in which:

- There are signs or symptoms resulting from the enlarged breasts (macromastia) that have not responded adequately to non-surgical interventions.
- To improve or correct asymmetry following cancer surgery on one breast. **Note:** either the involved breast or contralateral breast may be treated to achieve symmetry.

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**, pharmaceutical or metabolic process.
- Determining the symptoms are refractory to appropriately fitted supporting garments, or, following unilateral mastectomy, persistent with an appropriately fitted prosthesis or reconstruction therapy at the site of the absent breast.
- Determining that dermatologic signs or symptoms are refractory to or recurrent following a completed course of medical management.

For Medicare purposes, a 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 or symptoms:

- Back pain from macromastia, unrelied by:
  - Conservative analgesia.
  - Supportive measures (custom garment, etc.).
  - Physical therapy.
- Significant arthritic changes in the cervical or upper thoracic spine, optimally managed with persistent symptoms or significant restriction of activity.
- Intertriginous maceration, discoloration, chronic or recurrent infection of the inframammary skin refractory to dermatologic treatment measures.
- Shoulder grooving to a depth greater than 1 cm with skin irritation or darkening.
- Graphic documentation of ptosis with nipple-areolar complex 8 cm below the inframammary crease.
- Surgeon's Estimate of breast size/weight/volume exceeds 1000 grams with the need for at least 500 gram reduction per breast to relieve symptoms.

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 Schnur scale (abbreviated below) allows a rough estimate of the minimal amount of soft tissue to be removed to justify surgery to alleviate symptoms based on body surface area; breast tissue may be removed from the other breast in order to achieve symmetry.

**SCHNUR SCALE:**

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<td>1.91-2.00</td>
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<td>1000-1500g</td>
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<tr>
<td>BSA&gt;2.51</td>
<td>&gt;1500g</td>
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5. **Mastectomy for gynecomastia**

Gynecomastia is the excessive growth of the male mammary glands. These conditions can cause significant clinical manifestations when the excessive breast weight adversely affects the supporting structures of the shoulders, neck, and trunk.

Mastectomy with nipple preservation or reduction mammoplasty is considered reconstructive and a covered service for males with gynecomastia Grade III and IV or abnormal breast development with redundancy.

American Society of Plastic Surgeons’ gynecomastia scale:

- 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

6. **Gigantomastia of Pregnancy:**

Medicare considers subtotal mastectomy or reduction mammoplasty for the unusual condition of Gigantomastia of Pregnancy accompanied by any of the following complications (and delivery is not imminent) medically appropriate:
- Massive infection;
- Significant hemorrhage;
- Tissue necrosis with slough;
- Ulceration of breast tissue.

Medicare coverage of reduction mammoplasty is limited to those circumstances where the medical record supports the following:

- The signs or symptoms have been present for at least six months.
- Medical treatment or physical interventions have not adequately alleviated symptoms.

7. Rhinoplasty

Nasal surgery is defined as any procedure performed on the external or internal structures of the nose, septum or turbinate. This surgery may be performed to improve abnormal function, reconstruct congenital or acquired deformities, or to enhance appearance. It generally involves rearrangement or excision of the supporting bony and cartilaginous structures and incision or excision of the overlying skin of the nose.

Nasal surgery, including rhinoplasty, may be reconstructive or cosmetic in nature. Current CPT Codes do not allow distinction of cosmetic or reconstructive procedures by specific codes; therefore, categorization of each procedure is to be distinguished by the presence or absence of specific signs or symptoms.

8. Reconstructive Nasal Surgery

When nasal surgery, including rhinoplasty, is performed to improve nasal respiratory function, correct anatomic abnormalities caused by birth defects or disease, or revise structural deformities produced by trauma, the procedure should be considered reconstructive.

Rhinoplasty is considered medically necessary 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:

- 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 unresponsive to a recent trial of conservative medical management lasting at least six weeks that has either 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 deviation causing nasal airway obstruction that has proved unresponsive to a recent trial of conservative medical management lasting at least six weeks.
• 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 trans nasal areas when such access is required to perform medically necessary procedures (e.g., ethmoidectomy).
• Performed in association with cleft lip or cleft palate repair.
• 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.

Reconstructive nasal surgery is generally directed to improve nasal 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 congenital anatomic abnormalities (e.g., cleft lip nasal deformities, choanal atresia, oronasal or oromaxillary fistula); treat nasal cutaneous disease (e.g., rhinophyma, dermoid cyst); or to replace nasal tissue lost after tumor ablative surgery.

9. 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).

10. 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.

LCD Individual Consideration

Laser hair removal may be considered reconstructive and medically necessary when used to remove hair from transplanted flaps and skin rearrangements used to repair deficits caused by trauma or tumor extirpation. The medical record must support the indications for this service. Refer to Billing and Coding: Cosmetic and Reconstructive Surgery, A56587, for coding guidance.

Limitations

1. Cosmetic surgery performed to treat psychiatric or emotional problems is not covered.
2. 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.
3. Dermabrasion performed for post-acne scarring is classified as cosmetic and is not a covered benefit.
4. 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.
5. Panniculectomy is non-covered as primary treatment for back, hip, knee pain or dysfunction associated with osteoarthritis, vertebral or intervertebral disc disease or nerve compression syndromes.
6. Panniculectomy or removal of excess skin and soft tissue of the abdomen, chest, breasts, buttocks, and extremities is non-covered to treat redundancies resulting from weight loss or weight loss surgery when that tissue is without evidence of chronic infection, inflammation or ongoing necrosis post 3 months of appropriate therapy for the etiologic factor.

7. Abdominoplasty or panniculectomy are not covered when performed primarily for any of the following indications because it is considered cosmetic and not medically necessary (this list may not be all inclusive):

   - Treatment of neck or back pain.
   - Improving appearance (i.e., cosmesis).
   - Repairing abdominal wall laxity or diastasis recti.
   - Treating psychological disease, syndromes and symptoms or psychosocial complaints.
   - Treating disparities associated with body image and gender identity.
   - 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.

8. 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 is considered cosmetic and not covered as medically necessary.

9. Failed or infected implants originally placed for cosmetic purposes are not eligible for replacement as a Medicare covered service and will not be reimbursed.

10. Cosmetic surgery to reshape the breasts to improve appearance or self-image is not a Medicare benefit. Cosmetic signs or symptoms would include ptosis, poorly fitting clothing and beneficiary perception of unacceptable appearance.

11. Breast reduction or surgical mastectomy for gynecomastia, either unilateral or bilateral, is not the first line treatment. Medical therapy should be aimed at correcting any reversible causes (e.g., drug discontinuance). Furthermore, there is insufficient evidence that surgical removal is more effective than conservative management for pain due to gynecomastia.

12. Corrective facial surgery will be considered cosmetic rather than reconstructive 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. These situations will be handled through the redetermination process.

13. Thyroid chondoplasty to alter the appearance of the thyroid cartilage which is without functional defect is considered cosmetic.

14. Cosmetic Nasal Surgery
   When nasal surgery is performed solely to alter the patient's appearance or improve self-image in the absence of any signs or symptoms of functional abnormalities, the procedure should be considered cosmetic in nature and noncovered under the Medicare program.

15. Rhinoplasty is not covered when performed for either of the following indications because it is considered cosmetic in nature or not medically necessary:

   - Solely for the purpose of changing appearance.
   - As a primary treatment for an obstructive sleep disorder when the above criteria for approval have not been met.

Notice: Services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules. Refer to Billing and Coding: Cosmetic and Reconstructive Surgery, A56587, for applicable CPT codes and diagnosis codes.
The redetermination process may be utilized for consideration of services performed outside of the reasonable and necessary requirements in this LCD.

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

Coding Information:

Refer to the Local Coverage Article: Billing and Coding: Cosmetic and Reconstructive Surgery, A56587 for all coding information.

### Coding Information

**Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

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**Revenue Codes:**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.
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**CPT/HCPCS Codes**

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Group 1 Codes:

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**ICD-10 Codes that Support Medical Necessity**

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Group 1 Codes:

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**ICD-10 Codes that DO NOT Support Medical Necessity**

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**Additional ICD-10 Information**

N/A

**General Information**

**Associated Information**

**Documentation Requirements**

For all procedures:
1. All documentation must be maintained in the patient’s medical record and made available to the contractor upon request.
2. 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.
3. 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.
4. The medical record documentation must support the medical necessity of the services as stated in this policy.

Documentation Requirements for Specific Services

Dermabrasion

1. The medical record must describe the injury, surgery, or disease process that resulted in the defect.

Abdominal lipectomy/panniculectomy

1. The beneficiary’s medical record must contain the following information:
   - Description of the pannus and the underlying skin.
   - Documentation that the panniculus causes chronic intertrigo (dermatitis occurring on opposed surfaces of the skin, skin irritation, infection or chafing).
   - Description of conservative treatment undertaken and its results.

Mammoplasty:

1. The beneficiary's medical record must contain the following information:
   - Height and weight.
   - Clinical evaluation of the signs or symptoms ascribed to the macromastia, therapies prior to reduction mammoplasty and the responses to these therapies.
   - Mammogram report within preceding 18 months.
   - 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.

Rhinoplasty

1. The medical record must include photographic documentation of the following: frontal, lateral and worm’s eye view of the individual’s condition.
2. The medical record must include a description of the condition requiring the rhinoplasty.
3. When performed for chronic obstruction the medical record must indicate what is causing the obstruction.
4. The medical record should include a description of any conservative treatment that has been utilized to treat obstruction and the length of time that the conservative treatment has been trialed.

Septoplasty
1. The medical record must describe the conservative treatment utilized and the length of time that the treatment was trialed.
2. When the procedure is being done for asymptomatic septal deformity to gain access to other transnasal areas during another medically necessary procedure the medical record must indicate what surgical procedure is being performed.

**Utilization Guidelines**

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

**Sources of Information**

Contractor is not responsible for the continued viability of websites listed.

Contractor Medical Directors

Other Contractor Policies

Retired Noridian and Montana LCDs.

NAS Carrier Advisory Committee Members (based on the LCD for reduction mammaplasty developed by the intermediary contractor for Medicare Part A in Utah).


Aetna Clinical Policy Bulletin: Number: 0005, Septoplasty and Rhinoplasty

Aetna Clinical Policy Bulletin: number 0017, Breast Reduction Surgery and Gynecomastia Surgery


Original JH ICD-9 Source LCD L32763, Cosmetic and Reconstructive Surgery

Original JH ICD-10 Source LCD L35090, Cosmetic and Reconstructive Surgery

**Bibliography**

Jan-Feb, 26(1): 57-60.


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**Revision History Information**

<table>
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<tr>
<th>REVISION HISTORY DATE</th>
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<th>REVISION HISTORY EXPLANATION</th>
<th>REASON(S) FOR CHANGE</th>
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<td>05/30/2019</td>
<td>R5</td>
<td>LCD revised and published on 05/30/2019. The IOM Citations section was revised to add the section title to the CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 16: Section 10, 120 and 180, CMS IOM Publication 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 2, Sections 140.2, 140.4 and 250.5, CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 32: Section 260 and to add the Reasonable and Necessary IOM reference since the language contained in that reference and the reference was removed from the body of the policy. All billing and coding related information has been moved to the Local Coverage Article: Billing and Coding: Cosmetic and Reconstructive Surgery (A56587). The following ICD-10 codes have been added to the ICD-10 Code Group 3 of the Billing and Coding Article in response to an inquiry: Z90.11, Z90.12, Z90.13, and Z15.01. There was no change to coverage</td>
<td>Other (Change in LCD process per CR 10901)</td>
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| 04/14/2017            | R4                      | LCD revised and published on 06/08/2017 effective for dates of service on and after 04/14/2017 to remove the dual diagnosis code requirement in Group 4 for CPT code 19318 when ICD-10 diagnosis code Z48.3 is reported; ICD-10 diagnosis code N62 does not need reported when ICD-10 diagnosis code Z48.3 is reported. | • Other (Clarification)
| 12/31/2015            | R3                      | LCD revised to include reference to the original ICD-10 source. | • Other (Clarification) |
| 12/31/2015            | R2                      | LCD posted for notice on 11/05/2015. LCD becomes effective for dates of service on and after 12/31/2015 05/14/2015 DL35090 Draft LCD posted for comment. | • Creation of Uniform LCDs With Other MAC Jurisdiction
• Revisions Due To ICD-10-CM Code Changes |
| 10/01/2015            | R1                      | LCD revised to remove dermal injection information including HCPCS codes C9800, G0429, Q2026, and Q2028 and associated ICD-10 codes, B20, E88.1, and F43.21 effective for dates of service on or after 10/01/2014. (LCD Updated 05/08/2014). | • Other (Information is duplicative of NCD.) |

**Associated Documents**

**Attachments**

N/A

**Related Local Coverage Documents**

Article(s)

A56587 - Billing and Coding: Cosmetic and Reconstructive Surgery

**Related National Coverage Documents**

NCD(s)

140.2 - Breast Reconstruction Following Mastectomy
140.4 - Plastic Surgery to Correct "Moon Face"
250.5 - Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS)

**Public Version(s)**

Updated on 05/23/2019 with effective dates 05/30/2019 - N/A
Updated on 06/02/2017 with effective dates 04/14/2017 - 05/29/2019

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Keywords

N/A