

## Draft LCD for Cosmetic and Reconstructive Surgery (DL30733)

**Draft**

**Please note:** This is a Draft policy.

Draft LCDs are works in progress that are available on the Medicare Coverage Database site for public review. Draft LCDs are not necessarily a reflection of the current policies or practices of the contractor.

### Contractor Information

**Draft Draft Draft**

#### Contractor Name

Wisconsin Physicians Service Insurance Corporation

#### Contractor Number

00951, 00952, 00953, 00954, 05101, 05201, 05301, 05401, 05102, 05202, 05302, 05402, 52280

#### Contractor Type

Carrier, MAC, FI

### LCD Information

**Draft Draft Draft**

#### LCD ID Number

DL30733

#### LCD Title

Cosmetic and Reconstructive Surgery

#### Contractor's Determination Number

GSURG-032

#### AMA CPT / ADA CDT Copyright Statement

CPT codes, descriptions and other data only are copyright 2009 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply. Current Dental Terminology, (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. © 2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

#### CMS National Coverage Policy

CMS Pub. 100-3 Medicare National Coverage Determinations Manual

§140.2 - Breast Reconstruction Following Mastectomy

§140.4 - Plastic Surgery to Correct "Moon Face"

CMS Pub. 100-02 Medicare Benefit Policy Manual

180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare.

1862 (a)(1)(A) Medically Reasonable & Necessary.

1862 (a)(1)(D) Investigational or Experimental.

### **Primary Geographic Jurisdiction**

### **Oversight Region**

Region V

### **Projected Determination Effective Date**

### **Original Determination Ending Date**

### **Revision Effective Date**

### **Revision Ending Date**

### **Indications and Limitations of Coverage and/or Medical Necessity**

Indications and Limitations of Coverage and/or Medical Necessity

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

1. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, involitional defects, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

2. Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

B. Indications for specific surgical procedures:

1. Breast reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is covered (19316, 19318, 19324, 19325, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 19396)

The applicable ICD-9 codes include: V10.3, V51.0, 173.5, 174.0-174.9, 175.0-175.9, 198.2, 198.81, 217, 232.5, 233.0, 610.0-610.9

2. Removal or revision of a breast implant (CPT 19328, 19330, 19370, 19371, 19380) is considered medically necessary when it is removed for one of the following reasons:

- a. Mechanical complication of breast prosthesis; including rupture or failed implant, implant extrusion (996.54).
- b. Infection or inflammatory reaction due to a breast prosthesis; including infected breast implant, or rejection of breast implants (996.69).
- c. Other complication of internal breast implant; including siliconoma, granuloma, interference with diagnosis of breast cancer, painful capsular contracture with disfigurement (996.79)

3. Reduction Mammoplasty (CPT 19318) is the surgical reshaping of the breasts to reduce or lift enlarged or sagging breasts. Cosmetic surgery to reshape the breasts to improve appearance is not a Medicare benefit.

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: musculoskeletal, respiratory, and integumentary. Unilateral hypertrophy may result in symptoms following contralateral mastectomy.

Medical necessity for a reduction mammoplasty is limited to circumstances in which:

- There are signs and/or symptoms resulting from the enlarged breasts (macromastia) that have not responded adequately to non-surgical interventions, and

- To reduce the size of a normal breast to bring it into symmetry with a breast reconstructed after cancer surgery.

Non-surgical interventions preceding reduction mammoplasty should include as appropriate, but are not limited to, the following:

- Determining the macromastia is not due to an active endocrine or metabolic process
- Determining the symptoms are refractory to appropriately fitted supporting garments, or following unilateral mastectomy, persistent with an appropriately fitted prosthesis or reconstruction therapy at the site of the absent breast.
- Determining that dermatologic signs and/or symptoms are refractory to, or recurrent following, a completed course of medical management.

A medically reasonable and necessary reduction mammoplasty could be indicated in the presence of significantly enlarged breasts and the presence of at least one of the following signs and/or symptoms:

A. Back or neck or shoulder pain (719.41, 723.1, 724.1, 724.5) from macromastia (611.1) and unrelieved by:

1. Conservative analgesia,
2. Supportive measures (garment, etc.),
3. Physical Therapy, or
4. Significant arthritic changes in the cervical or upper thoracic spine, optimally managed with persistent symptoms and/or significant restriction of activity.

B. Intertriginous maceration or infection of the inframammary skin refractory to dermatologic measures. (695.89)

C. Permanent shoulder grooving with skin irritation by supporting garment (bra strap)(709.9)

The amount of breast tissue to be removed must be proportional to the body surface area (BSA) per the Schnur scale below:

Body Surface

Area (m<sup>2</sup>) Average grams of tissue per breast to be removed

1.40-1.50	218-260
1.51-1.60	261-310
1.61-1.70	311-370
1.71-1.80	371-441
1.81-1.90	442-527
1.91-2.00	528-628
2.01-2.10	629-750
2.11-2.20	751-895
2.21-2.30	896-1068
2.31-2.40	1069-1275
2.41-2.50	1276-1522
2.51-2.60	1523-1806
2.61-2.70	1807-2154
2.71-2.80	2155-2568
2.81-2.90	2569-3061
2.91-3.00	3062-3650

#### 4. Mastectomy for gynecomastia: (19300)

Gynecomastia is the excessive growth of the male mammary glands (611.1). These conditions can cause significant clinical manifestations when the excessive breast weight adversely affects the supporting structures of the shoulders, neck, and trunk. Payment may be made for this procedure if it is documented that the tissue is primarily breast tissue and not just adipose (fatty tissue).

5. Tattooing to correct color defects of the skin (11920, 11921, 11922) may be considered reconstructive (V51.0, V51.8) 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).

6. Punch graft hair transplant (CPT 15775-15776) may be considered reconstructive when it is performed for eyebrow(s) replacement following a burn injury or tumor removal (ICD-9 codes 173.3, 216.3, 232.3, 232.8, 238.2, 959.01, 941.27, 941.37).

7. Rhinoplasty (CPT codes 30400-30450) that is performed to improve nasal respiratory function due to airway obstruction or stricture, repair deficits caused by trauma, revise structural deformities produced by trauma or nasal cutaneous disease, or replace nasal tissue lost after tumor ablative surgery is covered.

a. Nasal fracture (802.0, 802.1)

b. Benign or malignant neoplasms (160.0, 170.0, 172.3, 173.3, 195.0, 212.0, 213.0, 216.3, 232.3)

c. Nasal Obstruction (478.19)

#### 8. Chemical Peel (15788-15793)

Is covered for the treatment of Actinic Keratosis (702.0).

#### 9. Dermabrasion, segmental, face (15781)

Is covered for the treatment of rhinophyma (695.3).

C. The following procedures will be considered on an individual basis.

1. Rhytidectomy, (15828, 15829) is considered medically necessary to correct a functional impairment as a result of a disease state ie; facial paralysis. Often this procedure is performed in conjunction with other procedures to correct the impairment.

2. Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty) (15830) will only be considered reasonable and medically necessary when these procedures are performed due to another surgery being done at the same time and would effect the healing of the surgical incision.

This procedure may also be considered to be medically necessary for the patient that has had a significant weight-loss following the treatment of morbid obesity and there are medical complications such as candidiasis, intertrigo or tissue necrosis that is unresponsive to oral or topical medication.

These claims will be reviewed by the medical staff and considered on a case by case basis. Medical Records will be requested by the Carrier to determine medical necessity. See Documentation Requirements section of this LCD.

### 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.**

#### 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.**

#### CPT/HCPCS Codes

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)

15775 - 15776

PUNCH GRAFT FOR HAIR TRANSPLANT; 1 TO 15 PUNCH GRAFTS - PUNCH GRAFT FOR HAIR TRANSPLANT; MORE THAN 15 PUNCH GRAFTS

15781

DERMABRASION; SEGMENTAL, FACE

15788 - 15793

CHEMICAL PEEL, FACIAL; EPIDERMAL - CHEMICAL PEEL, NONFACIAL; DERMAL

15828

RHYTIDECTOMY; CHEEK, CHIN, AND NECK

15829

RHYTIDECTOMY; SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM (SMAS) FLAP

15830

EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY

19300

MASTECTOMY FOR GYNECOMASTIA

19316

MASTOPEXY

19318

REDUCTION MAMMAPLASTY

19325

MAMMAPLASTY, AUGMENTATION; WITH PROSTHETIC IMPLANT

19328

REMOVAL OF INTACT MAMMARY IMPLANT

19330

REMOVAL OF MAMMARY IMPLANT MATERIAL

19340

IMMEDIATE INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR IN RECONSTRUCTION

19342

DELAYED INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR IN RECONSTRUCTION

19355

CORRECTION OF INVERTED NIPPLES

19357

BREAST RECONSTRUCTION, IMMEDIATE OR DELAYED, WITH TISSUE EXPANDER, INCLUDING SUBSEQUENT EXPANSION

19361

BREAST RECONSTRUCTION WITH LATISSIMUS DORSI FLAP, WITHOUT PROSTHETIC IMPLANT

19364

BREAST RECONSTRUCTION WITH FREE FLAP

19366

BREAST RECONSTRUCTION WITH OTHER TECHNIQUE

19367

BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP (TRAM), SINGLE PEDICLE, INCLUDING CLOSURE OF DONOR SITE;

19368

BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP (TRAM), SINGLE PEDICLE, INCLUDING CLOSURE OF DONOR SITE; WITH MICROVASCULAR ANASTOMOSIS (SUPERCHARGING)

19369

BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP (TRAM), DOUBLE PEDICLE, INCLUDING CLOSURE OF DONOR SITE

19370

OPEN PERIPROSTHETIC CAPSULOTOMY, BREAST

19371

PERIPROSTHETIC CAPSULECTOMY, BREAST

19380

REVISION OF RECONSTRUCTED BREAST

19396

PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT

30400 - 30450

RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR ELEVATION OF NASAL TIP - RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK AND OSTEOTOMIES)

### ICD-9 Codes that Support Medical Necessity

Note: ICD-9 codes must be coded to the highest level of specificity.

Breast Reconstruction (CPT Codes: 19316, 19318, 19324, 19325, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 19396)

173.5

OTHER MALIGNANT NEOPLASM OF SKIN OF TRUNK EXCEPT SCROTUM

174.0 - 174.9

MALIGNANT NEOPLASM OF NIPPLE AND AREOLA OF FEMALE BREAST - MALIGNANT NEOPLASM OF BREAST (FEMALE) UNSPECIFIED SITE

175.0 - 175.9

MALIGNANT NEOPLASM OF NIPPLE AND AREOLA OF MALE BREAST - MALIGNANT NEOPLASM OF OTHER AND UNSPECIFIED SITES OF MALE BREAST

198.2

SECONDARY MALIGNANT NEOPLASM OF SKIN

198.81

SECONDARY MALIGNANT NEOPLASM OF BREAST

217

BENIGN NEOPLASM OF BREAST

232.5

CARCINOMA IN SITU OF SKIN OF TRUNK EXCEPT SCROTUM

233.0

CARCINOMA IN SITU OF BREAST

610.0 - 610.9

SOLITARY CYST OF BREAST - BENIGN MAMMARY DYSPLASIA UNSPECIFIED

V10.3

PERSONAL HISTORY OF MALIGNANT NEOPLASM OF BREAST

V51.0	ENCOUNTER FOR BREAST RECONSTRUCTION FOLLOWING MASTECTOMY
Reduction Mammoplasty (CPT 19318)	
Primary Diagnosis:	
Primary diagnosis must be billed with one of the following secondary diagnoses:	
611.1	HYPERTROPHY OF BREAST
Secondary Diagnoses	
695.89	OTHER SPECIFIED ERYTHEMATOUS CONDITIONS
709.9	UNSPECIFIED DISORDER OF SKIN AND SUBCUTANEOUS TISSUE
719.41	PAIN IN JOINT INVOLVING SHOULDER REGION
723.1	CERVICALGIA
724.1	PAIN IN THORACIC SPINE
724.5	BACKACHE UNSPECIFIED
782.1	RASH AND OTHER NONSPECIFIC SKIN ERUPTION
Removal/ revision of a breast implant (CPT 19328, 19330, 19370, 19371, 19380)	
996.54	MECHANICAL COMPLICATION OF BREAST PROSTHESIS
996.69	INFECTION AND INFLAMMATORY REACTION DUE TO OTHER INTERNAL PROSTHETIC DEVICE IMPLANT AND GRAFT
996.79	OTHER COMPLICATIONS DUE TO OTHER INTERNAL PROSTHETIC DEVICE IMPLANT AND GRAFT
Mastectomy for gynecomastia (CPT 19300)	
611.1	HYPERTROPHY OF BREAST
Tattooing (CPT 11920, 11921, 11922)	
V51.0	ENCOUNTER FOR BREAST RECONSTRUCTION FOLLOWING MASTECTOMY
V51.8	OTHER AFTERCARE INVOLVING THE USE OF PLASTIC SURGERY
Punch graft hair transplant (CPT 15775-15776)	
173.3	OTHER MALIGNANT NEOPLASM OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
216.3	BENIGN NEOPLASM OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
232.3	CARCINOMA IN SITU OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
232.8	

CARCINOMA IN SITU OF OTHER SPECIFIED  
SITES OF SKIN

238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN
941.27	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF FOREHEAD AND CHEEK
941.37	FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE NOS) OF FOREHEAD AND CHEEK
959.01	OTHER AND UNSPECIFIED INJURY TO HEAD
Rhinoplasty (CPT codes 30400-30450) Use 478.19 to indicate nasal obstruction	
160.0	MALIGNANT NEOPLASM OF NASAL CAVITIES
170.0	MALIGNANT NEOPLASM OF BONES OF SKULL AND FACE EXCEPT MANDIBLE
172.3	MALIGNANT MELANOMA OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
173.3	OTHER MALIGNANT NEOPLASM OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
195.0	MALIGNANT NEOPLASM OF HEAD FACE AND NECK
212.0	BENIGN NEOPLASM OF NASAL CAVITIES MIDDLE EAR AND ACCESSORY SINUSES
213.0	BENIGN NEOPLASM OF BONES OF SKULL AND FACE
216.3	BENIGN NEOPLASM OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
232.3	CARCINOMA IN SITU OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
478.19	OTHER DISEASE OF NASAL CAVITY AND SINUSES
802.0	CLOSED FRACTURE OF NASAL BONES
802.1	OPEN FRACTURE OF NASAL BONES
Chemical Peel (15788-15793)	
702.0	ACTINIC KERATOSIS
Dermabrasion (CPT 15781)	
695.3	ROSACEA

**Diagnoses that Support Medical Necessity**

## **ICD-9 Codes that DO NOT Support Medical Necessity**

Elective surgery for purposes other than remedying health status

V50.0	ELECTIVE HAIR TRANSPLANT FOR PURPOSES OTHER THAN REMEDYING HEALTH STATES
V50.1	OTHER PLASTIC SURGERY FOR UNACCEPTABLE COSMETIC APPEARANCE

## **ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation**

## **Diagnoses that DO NOT Support Medical Necessity**

### **General Information**



### **Documentation Requirements**

The following documentation should be made available to the Carrier upon our request:

Reduction Mammoplasty documentation should include the evaluation and management note for the date of service and the note for the day the decision to perform surgery was made. The beneficiary's medical record must contain, and be available for review on request, the following information:

1. Height and weight.
2. Body Surface Area (BSA)
3. Clinical evaluation of the signs and/or symptoms ascribed to the macromastia, therapies prior to reduction mammoplasty and the responses to these therapies.
4. The operative report with documentation of the weight of tissue removed from each breast, obtained in the operating room.
5. The pathology report with the weight of the tissue removed from each breast.

Abdominoplasty documentation should include the evaluation and management note in which the decision to perform surgery was made, surgical note and any notes indicating medical complications necessitating the surgery.

Rhytidectomy documentation should include the evaluation and management note in which the decision to perform surgery was made, surgical note and any notes documenting the functional impairment.

Pre-operative photographs must be made available upon Carrier request for punch graft hair transplants.

Documentation in the progress notes for tattooing, to correct color defects of the skin must indicate the prior condition i.e. post-mastectomy, trauma necessitating the reconstruction.

## **Appendices**

### **Utilization Guidelines**

See companion article GSURG-032 Billing and Coding Instructions for Cosmetic Services

\* - An asterisk indicates a revision to that section of the policy.

### **Sources of Information and Basis for Decision**

Other Medicare Contractors Policies

Bogetti P, Boltri M, Spagnoli G, Dolcet M. Aesthetic Plast Surg. 2002 Jan-Feb, 26(1): 57-60 Surgical treatment of rhinophyma: a comparison of techniques

Curnier A, Choudhary S. Ann of Plast Surg, 2002 August; 49(2): 211-4 Triple approach to rhinophyma

Gupta S, Handa S, Saraswat A, Kumar B. J Dermatol. 2000 Feb; 27(2): 116-20 Conventional cold excision combined with dermabrasion for rhinophyma

Jung H. Facial Plast Surgery, 1998; 14(4): 255-78 Rhinophyma: plastic surgery, rehabilitation, and long-term results

### **Advisory Committee Meeting Notes**

Advisory Committee Meeting Notes

Meeting Date:

Wisconsin: 2/12/2010

Illinois: 1/13/2010

Michigan: 1/27/2010

Minnesota: 1/14/2010

J-5 MAC

(IA,KS, MO, NE) 2/19/2010

Open LCD meeting

01/06/2010

### **Start Date of Comment Period**

02/19/2010

### **End Date of Comment Period**

04/05/2010

### **Start Date of Notice Period**

**Revision History Number**

**Revision History Explanation**

**Reason for Change**

**Last Reviewed On Date**

12/04/2009

**Related Documents**

This LCD has no Related Documents.

**LCD Attachments**

Coding and Billing Guidelines (PDF - 37,731 bytes)

**Draft Contact**

Kenneth Bussan - [Kenneth.Bussan@wpsic.com](mailto:Kenneth.Bussan@wpsic.com)  
WPS Medicare  
1717 W. Broadway  
Madison, WI 53701-1787

**All Versions**



Updated on 12/11/2009 with effective dates N/A - N/A