Local Coverage Determination (LCD): Plastic Surgery (L35163)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	A and B MAC	01111 - MAC A	J - E	California - Entire State
Noridian Healthcare Solutions, LLC	A and B MAC	01112 - MAC B	J - E	California - Northern
Noridian Healthcare Solutions, LLC	A and B MAC	01182 - MAC B	J - E	California - Southern
Noridian Healthcare Solutions, LLC	A and B MAC	01211 - MAC A	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01212 - MAC B	J - E	American Samoa Guam Hawaii Northern Mariana Islands
Noridian Healthcare Solutions, LLC	A and B MAC	01311 - MAC A	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01312 - MAC B	J - E	Nevada
Noridian Healthcare Solutions, LLC	A and B MAC	01911 - MAC A	J - E	American Samoa California - Entire State Guam Hawaii Nevada Northern Mariana Islands

LCD Information

Document Information

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LCD Title
Plastic Surgery

Proposed LCD in Comment Period
N/A

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N/A

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10/09/2017

CMS National Coverage Policy

Title XVIII of the Social Security Act, §1862(a)(1)(A). Allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, §1833(e). Prohibits Medicare payment for any claim, which lacks the necessary information to process the claim.

Title XVIII of the Social Security Act, §1862(a)(10). Coverage of cosmetic surgery is discussed.

Medicare On-Line Manual System, Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 16, §§10, 120, and 180.

Medicare On-Line Manual System, Publication 100-03, *Medicare National Coverage Determinations Manual,* Chapter 1, Part 2, §§140.2 and 140.4.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

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 appearance.

Transgender Surgery
This policy does not address coverage for procedures associated with transgender surgery. All coverage determinations for transgender surgery are currently handled by individual consideration on a case by case review with particular consideration of the World Professional Association for Transgender Health (WPATH) Standards of Care as interpreted through the various Medicare statutes, rules, regulations, and Manual instructions.

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

As it regards a Medicare covered benefit the *Medicare Internet Only Manual 100-02 Chapter16 states:*
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.

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

Cosmetic surgery performed purely for the purpose of enhancing one's appearance is not eligible for coverage. Cosmetic surgery performed to treat psychiatric or emotional problems is not covered.

Corrective facial surgery will be considered cosmetic rather than reconstructive when there is no functional impairment present.

If a noncovered cosmetic surgery is performed in the same operative period as a covered surgical procedure, benefits will be provided for the covered surgical procedure only.

Benefits may be provided for complications arising from cosmetic surgery. Such complications include infection, hemorrhage, or other serious documented medical complication.

Payment may be made for the following procedures when performed for the reasons indicated:

1. Reduction Mammoplasty
Macromastia (also called breast hypertrophy) is an increase in the volume and weight of breast tissue relative to the general body habitus. Macromastia may adversely affect other body systems: such as musculoskeletal, respiratory, and integument (skin). These symptoms include but are not necessarily limited to:

1. Muscle strain such as backache, neck pain, shoulder pain and less often upper extremity peripheral neuropathy and/or headache;
2. Problems associated with excess breast weight and brassiere support such as clavicular bra strap grooves;
3. Hygiene problems such as intertrigo, exacerbation of acne in the folds underneath the breast and/or local hidradenitis supprativa refractory to usual medical care;
4. Clearly demonstrated interference with normal activities of daily living as noted as noted by a breast specific questionnaire for ADLs;

Reduction mammoplasty is covered by Medicare when it is performed:

1. To reduce the size of the hypertrophic breast(s) and reduce or alleviate symptoms caused by the breast hypertrophy, or
2. To reduce the size of a normal breast to bring it into symmetry with a breast reconstructed after breast 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.

For Medicare purposes, a reasonable and necessary reduction mammoplasty may be indicated in the presence of

significantly enlarged breasts and the presence of **at least two** of the following signs and/or symptoms when the breast hypertrophy and the symptoms and signs have been present for at least six months and have not responded to a reasonable non-surgical care program:

- Upper back, shoulder and /or neck pain that appears to be directly correlated to the macromastia
- Headache (cephalgia) when same can be directly attributed to the excessive breast weight and its effect on the neck and/or shoulders and other reasonable causes of a headache have been addressed/ruled out
- Significant thoracic kyphosis which is felt to be directly correlated to the breast hypertrophy.
- Chronic breast pain due to the excessive weight of the breasts.
- Intertriginous maceration or infection of the inframammary skin refractory to usual dermatologic measures.
- Shoulder grooving from supporting garment (bra strap).
- Upper extremity paresthesia due to brachial plexus compressions syndrome secondary to the weight of the breasts being transferred to the shoulder strap area

The MAC understands that conservative measures are often not effective or sustained however given the risks of surgery these measures should be attempted for a reasonable period of time as some patients will respond and be able to avoid surgery and the inherent surgical risks. Complications of reduction mammaplasty surgery include but are not limited to:

- Infection
- Delayed wound healing
- Wound dehiscence
- Hematoma and/or seroma
- Skin or nipple-areola necrosis
- Fat necrosis
- Cosmetic deformity
- Unfavorable scarring
- Alteration of nipple sensation
- Thromboembolic complications (blood clots)
- Inability to breast feed
- Need for surgical revision
- Need for physical therapy
- Potential for anesthesia related complications

Considerable attention has been given to the amount of breast tissue removed in differentiating between cosmetic and medically necessary reduction mammoplasty. Evidence indicates that patients experience similar preoperative breast hypertrophy related symptoms and similar postoperative symptom relief after reduction mammaplasty regardless of resection volume

In a prospective trial of 188 patients undergoing reduction mammaplasty for macromastia related symptoms the degree of relief was not correlated with the amount of breast volume removed. The surgeon must document in the clinical records the amount of tissue reduction anticipated and the rationale on how that amount was determined.

Medicare coverage of reduction mammoplasty is limited to those circumstances where the medical record supports medical necessity and reasonableness criteria including:

- The signs and/or symptoms have been present for at least six months
- Medical treatment and/or physical interventions have not adequately alleviated symptoms
- The patient has been informed of the risks of complications
- The notes indicate the proposed amount of tissue to be removed and the rationale supporting that

determination

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

2. 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

3. Mastectomy for gynecomastia
Gynecomastia is the excessive growth of the male mammary glands. This condition may 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

4. 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, and the above symptoms have been present for at least three months and are refractory to usual standard medical therapy, such surgery may be considered reconstructive. Preoperative photographs may be required to support justification and should be supplied upon request.

5. Suction-Assisted Lipectomy
Suction-assisted lipectomy is a surgical procedure employing high vacuum pressure to suction away localized collections of unwanted fat. When the procedure is utilized to remove a lipoma, it is considered reconstructive surgery. The clinical record must clearly demonstrate medical necessity for the lipoma removal as most such tumors are benign and do not require removal. All other uses are currently considered cosmetic in nature and non-covered

6. Dermabrasion
Coverage will be provided when correcting defects resulting from traumatic injury, surgery, burns or disease. Dermabrasion following burn scarring is usually accomplished in 3-4 treatments. If the results are not optimum,

other treatments may be undertaken. Dermabrasion performed post acne scarring is classified as cosmetic and is not covered for payment.

7. Rhytidectomy
Coverage will be provided when functional impairment as a result of a disease state exists (e.g., facial paralysis).

8. Blepharoplasty and Blepharoptosis
These procedures are addressed in a separate Noridian LCD.

9. 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.

10. Cosmetic Nasal Surgery
Nasal surgery performed solely to improve the patient's appearance in the absence of any signs and/or symptoms of functional abnormalities, should be considered cosmetic in nature is noncovered under the Medicare Program.

11. 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 may be considered reconstructive.

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.

Compliance with the provisions in this policy is subject to monitoring by post payment data analysis and subsequent medical review.

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

General Information

Associated Information

For Reduction Mammoplasty:
1. Physicians should document the severity of the symptoms of breast hypertrophy and impact on health related quality of life as measured by an accepted breast specific questionnaire.
The beneficiary's medical record must contain the following information and be made available to any authorized Medicare auditor upon request:

- Height and weight
- Clinical evaluation of the signs and/or symptoms ascribed to the macromastia, therapies prior to reduction mammoplasty and the responses to these therapies.
- 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.

2. Reasons for denial include:

1. Surgery is deemed or later determined to be cosmetic in nature. Breast surgery for uncomplicated macromastia, pendulous breasts, or to correct otherwise uncomplicated nipple inversions will be considered cosmetic and not reasonable and necessary.
2. Failure to clearly document persistent signs and symptoms despite a reasonable trial of conservative therapy for a reasonable length of time.
3. Services submitted without a listed diagnosis (ICD-10-CM) code supporting medical necessity.
4. Use of any ICD-10-CM codes not listed in the ICD-10-CM Codes That Support Medical Necessity Section of the Billing and Coding: Plastic Surgery article (A57221).

For all procedures noted within this policy:
The medical record must be made available to Medicare or a Medicare auditor upon request.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services may be denied as not reasonable and necessary.

When requesting a written redetermination, providers must include all relevant documentation with the request. Failure to include such items will likely result in an unfavorable determination. While not required, high quality photographs may be useful in determining medical necessity and may be submitted when the provider feels it is appropriate to do so.

Sources of Information

1. Retired Noridian and Montana LCDs
2. This LCD is based on the LCD for Reduction Mammaplasty developed by the intermediary contractor for Medicare Part A in Utah.
   The following references are from that policy: *American Society of Plastic Surgeons. Reduction mammaplasty*.

Recommended criteria for third-party payer coverage 2011. Available at: http://www.plasticsurgery.org.
3. Schnur PL, Hoehn JG, Ilstrup DM, et al. Reduction mammaplasty: Cosmetic or reconstructive procedure? *Ann Plast Surg.* 1991;27(3):232-237.
4. Schnur PL. Reduction mammaplasty - The Schnur Sliding Scale revisited. *Ann Plast Surg.* 1999;42(1):107-108.
5. Mosteller RD. Simplified calculation of body-surface area. *NEJM.* 1987;317:1098
6. Coleman, E., Bockting, W., et al. Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. *International Journal of Transgenderism* 2011; 13:165-232

NOTE: Some of the websites used to create this policy may no longer be available.

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
10/01/2019	R4	At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy. LCD was converted to the "no-codes" format.	• Revisions Due To Code Removal
10/01/2019	R3	10/01/2019: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy. ICD10 Codes added: I70.238; I70.248 to Group II Codes	• Revisions Due To ICD-10-CM Code Changes
10/10/2017	R2	12/20/2017: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.	• Provider Education/Guidance

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		Verbiage for Group 4 Coding for Reduction Mammaplasty changed to add: Use one of the C50.xx ICD-10 codes listed as a secondary diagnosis with primary diagnosis N65.1.	
10/10/2017	R1	At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.	• Creation of Uniform LCDs Within a MAC Jurisdiction

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)
A57221 - Billing and Coding: Plastic Surgery
A55684 - Response to Comments: Plastic Surgery
LCD(s)
DL35163
- (MCD Archive Site)

Related National Coverage Documents

N/A

Public Version(s)

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- Surgery