

Billing and Coding Guidelines for Cosmetic and Reconstructive Surgery LCD

The following procedures may be considered reconstructive or cosmetic. Cosmetic procedures and/or surgery are statutorily excluded by Medicare. These services will be denied as non-covered. **Non-covered procedures do not need to be billed to the Contractor.** If the beneficiary requests a claim be submitted for a cosmetic procedure, then use the billing instructions below to receive a non-covered cosmetic denial. See WPS LCD L34698 for coverage of the services that are reconstructive and therefore, medically necessary.

Cosmetic surgery can be defined as a procedure that is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. These procedures can be performed for medically necessary or cosmetic reasons. See WPS LCD L34698 for the criteria for medically necessary services. Information below is to assist with billing for these services when they are performed for cosmetic reasons.

When the following procedures are being performed for cosmetic reasons use diagnosis code

Z41.1 Encounter for cosmetic surgery and the claim will be denied.

1. Reduction Mammoplasty (CPT 19318)
 This procedure will be denied when performed for a cosmetic reason.
2. Mastectomy for gynecomastia (19300):
 If the tissue removed is primarily fatty tissue, the surgery is classified as cosmetic and will be denied as non-covered.
3. Rhinoplasty (CPT codes 30400-30450)
 When nasal surgery is performed solely to improve the patient's appearance in the absence of any signs and/or symptoms of functional abnormalities, it is considered cosmetic and will be denied as non-covered.
4. Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty) (15830) is not covered when performed to improve the patient's appearance.
5. Chemical Peel (15788-15793)
 For cosmetic reasons will be denied as not covered
6. Dermabrasion, segmental, face (15781) performed for a cosmetic reason will be denied as non-covered.
7. Rhytidectomy (15828, 15829) performed for a cosmetic reason will be denied as non covered.
8. The following CPT codes/procedures are generally considered cosmetic and may be medically reviewed or denied as non-covered:

11950-11954	Injection of filling material (collagen)
15780, 15782, 15783	Dermabrasion (eg. acne scarring, fine wrinkling...)
15819	Cervicoplasty
15824-15826	Rhytidectomy
15832-15839	Excision, excessive skin and subcutaneous tissue, including lipectomy
15876-15879	Suction -assisted lipectomy

17340	Cryotherapy for acne
17360	Chemical exfoliation
17380	Electrolysis
69300	Otoplasty

9. Punch graft hair transplant (CPT 15775-15776)
Performed for a cosmetic reason will be denied as non-covered.
10. Billing for dermal injections for the treatment of Facial Lipodystrophy Syndrome (LDS) that meet the criteria in the NCD:

G0429 Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)

Q2026 Radiesse injection Injection, Radiesse, 0.1ml
Q2028 Sculptra injection Injection, Sculptra, 0.5mg

Regulation Excerpts:

CMS Pub. 100-04 Medicare Claims Processing Manual, Chapter 32 - Billing Requirements for Special Services, Sections:

260.2.1 – Hospital Billing Instructions

(Rev. 2998, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01-12 - ASC X12, Implementation: 08-25-2014 - ASC X12; Upon Implementation of ICD-10)

A - Hospital Outpatient Claims

For hospital outpatient claims, hospitals must bill covered dermal injections for treatment of facial LDS by having all the required elements on the claim:

A line with HCPCS codes Q2026 or Q2028 with a Line Item Date of service (LIDOS) on or after March 23, 2010,

A line with HCPCS code G0429 with a LIDOS on or after March 23, 2010, and

diagnosis codes B20 (HIV) and E88.1 (Lipodystrophy).

The applicable NCD is 250.5 Facial Lipodystrophy.

B - Outpatient Prospective Payment System (OPPS) Hospitals or Ambulatory Surgical Centers (ASCs):

HCPCS code G0429 replaces HCPCS code C9800, Table 48.-CY 2016 OPPS/ASC Final Rule effective January 1, 2017.

For line item dates of service on or after March 23, 2010, and until HCPCS codes Q2026 and Q2027 are billable, facial LDS claims shall contain a temporary HCPCS code C9800, instead of HCPCS G0429 and HCPCS Q2026/Q2027, as shown above.

C - Hospital Inpatient Claims

Hospitals must bill covered dermal injections for treatment of facial LDS by having all of the required elements on the claim:

- *Discharge date on or after March 23, 2010,*

ICD-10-PCS procedure code 3E00XGC Introduction of Other Therapeutic Substance into Skin and Mucous-Membrances, External Approach, or

ICD-10-CM diagnosis codes B20 Human Immunodeficiency Virus [HIV] disease and E88.1 Lipodystrophy not elsewhere classified.

260.2.2 – Practitioner Billing Instruction

(Rev. 2998, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01-12 - ASC X12, Implementation: 08-25-2014 - ASC X12; Upon Implementation of ICD-10)

Practitioners must bill covered claims for dermal injections for treatment of facial LDS by having all the required elements on the claim:

Performed in a non-facility setting:

A line with HCPCS codes Q2026 or Q2028 with a LIDOS on or after March 23, 2010,

A line with HCPCS code G0429 with a LIDOS on or after March 23, 2010, and

ICD-10-CM diagnosis codes B20 (HIV) and E88.1 (Lipodystrophy not elsewhere classified).

Performed in a facility setting:

A line with HCPCS code G0429 with a LIDOS on or after March 23, 2010,

ICD-10-CM diagnosis codes B20 Human Immunodeficiency Virus (HIV) disease and E88.1 (Lipodystrophy not elsewhere classified).

Coding Guidelines

1. Claims do not have to be submitted for cosmetic procedures. However, if a denial of Medicare coverage is necessary, a GY modifier (items or services statutorily excluded or does not meet the definition of any Medicare benefit) can be used on a cosmetic procedure to receive a non-covered denial.
2. All submitted non-covered or no payment claims using condition code 21 will be processed to completion, and all services on those claims, since they are submitted as non-covered, will be denied. The default liability for payment of these claims is assigned to the beneficiary, who may then submit the denial from Medicare, as the primary payer, to subsequent payer(s) for consideration. Since a denial is a Medicare determination of payment, all services submitted on no payment claims may be appealed later if unusual circumstances so warrant. That is, all payment determinations are subject to appeal, even denials of services submitted as non-covered.

CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage, Section 120 - Cosmetic Surgery

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.

CMS PUB. 100-02 Medicare Benefit Policy Manual Chapter 16 –General Exclusions from Coverage, Section §180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare. (Rev. 189, Issued: 06-27-14, Effective: 05-30-14, Implementation: 06-29-14)

*Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services "related to" **non-covered** services (e.g., cosmetic surgery, **non-covered** organ transplants, **non-covered** artificial organ implants, etc.), including services related to follow-up care and complications of **non-covered** services which require treatment during a hospital stay in which the **non-covered** service was performed, are not covered services under Medicare. Services "not related to" **non-covered** services are covered under Medicare.*

*Following are examples of services "related to" and "not related to" **non-covered** services while the beneficiary is an inpatient:*

- A beneficiary was hospitalized for a **non-covered** service and broke a leg while in the hospital. Services related to care of the broken leg during this stay is a clear example of "not related to" services and are covered under Medicare.*
- A beneficiary was admitted to the hospital for covered services, but during the course of hospitalization became a candidate for a **non-covered** transplant or implant and actually received the transplant or implant during that hospital stay. When the original admission was entirely unrelated to the diagnosis that led to a recommendation for a **non-covered** transplant or implant, the services related to the admitting condition would be covered.*
- A beneficiary was admitted to the hospital for covered services related to a condition which ultimately led to identification of a need for transplant and receipt of a transplant during the same hospital stay. If, on the basis of the nature of the services and a comparison of the date they are received with the date on which the beneficiary is identified as a transplant candidate, the services could reasonably be attributed to preparation for the non-covered transplant, the services would be "related to" **non-covered** services and would also be non-covered.*

*Following is an example of services received subsequent to a **non-covered** inpatient stay:*

*After a beneficiary has been discharged from the hospital stay in which the beneficiary received **non-covered** services, medical and hospital services required to treat a condition or complication that arises as a result of the prior **non-covered** services may be covered when they are reasonable and necessary in all other respects. Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous **non-covered** procedure. Some examples of services that may be found to be covered under this policy are the reversal of intestinal bypass surgery for obesity, complications from cosmetic surgery, removal of a **non-covered** bladder stimulator, or treatment of any infection at the surgical site of a **non-covered** transplant that occurred following discharge from the hospital.*

However, any subsequent services that could be expected to have been incorporated into a global fee are not covered. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's progress, these visits are not covered.

**CMS PUB. 100-03 Medicare National Coverage Determinations Manual Chapter 1, Part 2
Section §140.2 - Breast Reconstruction Following Mastectomy**

During recent years, there has been a considerable change in the treatment of diseases of the breast such as fibrocystic disease and cancer. While extirpation of the disease remains of primary importance, the quality of life following initial treatment is increasingly recognized as of great concern. The increased use of breast reconstruction procedures is due to several factors:

- *A change in epidemiology of breast cancer, including an apparent increase in incidence;*
- *Improved surgical skills and techniques;*
- *The continuing development of better prostheses; and*
- *Increasing awareness by physicians of the importance of postsurgical psychological adjustment*

Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered a relatively safe and effective non-cosmetic procedure. Accordingly, program payment may be made for breast reconstruction surgery following removal of a breast for any medical reason.

Program payment may not be made for breast reconstruction for cosmetic reasons. (Cosmetic surgery is excluded from coverage under Title XVIII of the Social Security Act (SSA) §1862(a)(10) of the Act.)

CMS PUB. 100-03 Medicare National Coverage Determinations Manual Chapter 1, Part 2, Section §140.4 - Plastic Surgery to Correct "Moon Face"

The cosmetic surgery exclusion precludes payment for any surgical procedure directed at improving appearance. The condition giving rise to the patient's preoperative appearance is generally not a consideration. The only exception to the exclusion is surgery for the prompt repair of an accidental injury or for the improvement of a malformed body member which coincidentally serves some cosmetic purpose. Since surgery to correct a condition of "moon face" which developed as a side effect of cortisone therapy does not meet the exception to the exclusion, it is not covered under Medicare (§1862(a)(10) of the Act).

**CMS PUB. 100-03 Medicare National Coverage Determinations Manual Chapter 1, Part 4
Section § 250.5 - Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) -
Effective March 23, 2010 (Rev. 122, Issued: 06-04-10, Effective: 03-23-10, Implementation: 07-06-10)**

A. General

Treatment of persons infected with the human immunodeficiency virus (HIV) or persons who have Acquired Immune Deficiency Syndrome (AIDS) may include highly active antiretroviral therapy (HAART). Drug reactions commonly associated with long-term use of HAART include metabolic complications such as, lipid abnormalities, e.g., hyperlipidemia, hyperglycemia, diabetes, lipodystrophy, and heart disease. Lipodystrophy is characterized by abnormal fat distribution in the body.

The LDS is often characterized by a loss of fat that results in a facial abnormality such as severely sunken cheeks. The patient's physical appearance may contribute to psychological conditions (e.g., depression) or adversely impact a patient's adherence to antiretroviral regimens (therefore jeopardizing their health) and both of these are important health-related outcomes of interest in this population. Therefore, improving a patient's physical appearance through the use of dermal injections could improve these health-related outcomes.

B. Nationally Covered Indications

Effective for claims with dates of service on and after March 23, 2010, dermal injections for LDS are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in HIV-infected beneficiaries when LDS caused by antiretroviral HIV treatment is a significant contributor to their depression.

C. Nationally Non-Covered Indications

- 1. Dermal fillers that are not approved by the FDA for the treatment of LDS.*
- 2. Dermal fillers that are used for any indication other than LDS in HIV-infected individuals who manifest depression as a result of their antiretroviral HIV treatments.*

Revision History:

01/01/2017 CPT code updates: removed code C9800, Annual review 12/02/2016

02/01/2016 -Annual Review with formatting changes completed on 01/05/2016.

02/01/2015- Annual Review -01/05/2015, updates manual references.

08/01/2014-updated regulation excerpts based on CR 8825 & removed AWP and WAC pricing info under #10; removed ICD-9 codes 042, 272.6 and added B20 and E88.1.