- 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 breast reduction could be indicated in the presence of significantly enlarged breasts and the presence of at least one of the following signs and/or symptoms:

- Back, neck or shoulder pain from macromastia and unrelieved by 6 months of:
  - Conservative analgesia,
  - Supportive measures (garment, etc.),
  - Physical Therapy, or
- Significant arthritic changes in the cervical or upper thoracic spine, optimally managed with persistent symptoms and/or significant restriction of activity, or
- Intertriginous maceration or infection of the inframammary skin refractory related to dermatologic measures.
- Permanent shoulder grooving with skin irritation by supporting garment (bra strap).

The amount of breast tissue to be removed must be proportional to the body surface area (BSA) per the Schnur18 scale below. If the individual's body surface area and weight of breast tissue removed fall above the 22nd percentile, then the surgery is considered medically reasonable and necessary with the appropriate criteria. If only one breast meets the Schnur scale criteria; breast tissue may be removed from the other breast in order to achieve symmetry.

Schnur Scale:

Body Surface Area (m2)	**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
   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.

   - Persists more than 3 to 4 months after the pathological causes are ruled out (e.g. not limited to testosterone deficiency, testicular tumor, liver disease, or drug induced).[34]
   - Persists after 3 to 4 months of unsuccessful medical treatment for pathological gynecomastia.[16]
   - Pain or tenderness directly related to the breast tissue which has a clinically significant impact upon activities of daily living.
   - Clinical symptoms refractory to a trial of analgesics or anti-inflammatory agents.
   - For significant clinical manifestations when the excessive breast weight adversely affects the supporting structures of the shoulders, neck and trunk.

   American Society of Plastic Surgeons' gynecomastia scale:[16]

   - Grade I: Small breast enlargement with localized button of tissue that is concentrated around the areola.
   - 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
5. 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 reasonable and necessary when signs or symptoms are refractory to medical treatment or physical interventions have not adequately alleviated symptoms such as:
   - Massive infection
   - Significant hemorrhage
   - Tissue necrosis with slough
   - Ulceration of breast tissue
   - Intertriginous maceration or infection of the inframammary skin refractory to dermatologic measures.
6. 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).
7. 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.

Nasal surgery is defined as any procedure performed on the external or internal structures of the nose, septum or turbinate. 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.

Rhinoplasty is a procedure that changes the shape or appearance of the nose while improving or preserving the nasal airway. The primary purpose for Rhinoplasty can be functional, aesthetic, or both and may include other procedures on the paranasal sinuses, septum, or turbinates.[13]

Septoplasty is a procedure used to correct deformities of the nasal septum which can often cause issues with airflow and difficulty breathing.[23]

8. Rhinoplasty is considered medically reasonable and necessary when the procedure is performed for correction and repair of any of the following indications:
    - Secondary to trauma, disease, congenital defect with nasal airway obstruction that has not resolved after previous septoplasty/turbinectomy or would not be expected to resolve with septoplasty/turbinectomy alone.[19]
    - chronic, non-septal, nasal obstruction due to vestibular stenosis (i.e., collapsed internal valves).
    - nasal deformity secondary to a cleft lip/palate or other congenital craniofacial deformity causing a functional impairment. (e.g., cleft lip nasal deformities, choanal atresia, oronasal or oromaxillary fistula)[13]

    Septoplasty is considered medically necessary when performed for any of the following indications:

    - septal deviation/deformity causing nasal airway obstruction that has proved unresponsive to a trial of conservative medical management lasting at least 6 weeks (e.g. topical nasal corticosteroids, decongestants, antibiotic, allergy evaluation and therapy, etc.).[22, 23]
    - recurrent sinusitis (4 or more episodes in a year) secondary to a deviated septum that does not resolve after appropriate medical and antibiotic therapy., [20, 23]
    - recurrent epistaxis (4 or more significant episodes) related to a septal deformity.[20]
    - 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.[21]
    - 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.[14]

9. Chemical Peel
   Is covered for the treatment of Actinic Keratosis.
10. Dermabrasion is considered medical reasonable and necessary 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. Rhinophyma is characterized by skin thickening, which can cause an enlargement of the nose due to excess tissue and overgrowth of sebaceous glands.[7] Rhinophyma in its most severe cases can affect breathing and even vision.[3,7]
11. Dermal injections for facial lipodystrophy syndrome (LDS) using dermal fillers approved by the FDA for this purpose, and then only in human immunodeficiency virus (HIV)-infected Medicare beneficiaries who manifest depression secondary to the physical stigma of HIV treatment will be covered. Effective for claims with dates of service on and after March 23, 2010.
    - See Pub. 100-03, *Medicare National Coverage Determinations* Chapter 1, Coverage Determinations Part 4, Section 250.5 Dermal Injection for the Treatment of Facial Lipodystrophy Syndrome.
    - See Pub. 100-04, *Claims Processing Manual*, Chapter 32, Section 260, Dermal Injection for the Treatment of Facial Lipodystrophy Syndrome.
12. Abdominal Lipectomy/Panniculectomy
    - 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 or remains refractory to appropriate medical therapy (e.g. topical antifungals, corticosteroids, antibiotics) over a period of 3 months.[12]
    - When surgery is performed to alleviate such complicating factors as inability to walk normally due to pannus size, 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.[12]
    - This procedure may also be medically necessary for the patient that has had a significant weight-loss following the treatment of morbid obesity, in addition to meeting the criteria noted above, there should be evidence that the individual has maintained a stable weight for at least 6 months. If the weight loss is the result of bariatric surgery, abdominoplasty/panniculectomy should not be performed until at least 18 months after bariatric surgery and only when weight has been stable for at least the most recent 6 months and infection and inflammation has continued for the most recent 3 months.[12]

C. The following procedures are non-covered for the following indications.

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
    - Post-acne scarring
    - Rosacea other than rhinophyma
    - All other indications not identified as covered in the section above
4. Abdominal Lipectomy/Panniculectomy
    - Repairing abdominal wall laxity, or diastasis recti

- Redundancies resulting from weight loss or weight loss surgery when that tissue is without evidence of chronic infection or inflammation that is refractory to conservative treatment as outlines in the indications listed above.
- Solely to improve appearance
- All other indications unless covered in the section above

Note: Abdominal Lipectomy/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. 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.
6. Reconstructive Breast Surgery: Removal of Breast Implants for re-implantation of an implant inserted for cosmetic purposes only and not for history of mastectomy for treatment of breast cancer, lumpectomy, or treatment of contralateral breast to bring it into symmetry with a reconstructed breast following cancer surgery is not a covered Medicare benefit.
7. Reduction Mammaplasty
    - Surgery performed primarily to reshape the breasts to improve appearance or self-image.
    - Mammapexy unrelated to breast reconstruction following a medically necessary mastectomy.
8. Mastectomy for gynecomastia
    - Breast reduction or surgical mastectomy for gynecomastia, either unilateral or bilateral, as the first line treatment.
    - When performed solely to improve appearance of the male breast or to alter contours of the chest wall.
9. Gigantomastia of Pregnancy
    - Surgery to reshape the breasts to improve appearance or self-image.
    - All other indications not identified as covered in the section above.
10. 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 appeal process.
11. Thyroid chrondoplasty to alter the appearance of the thyroid cartilage which is without functional defect is considered cosmetic.
12. 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 or improving self-image in the absence of any signs or symptoms of functional abnormalities.
    - As a primary treatment for an obstructive sleep disorder when the above criteria for approval have not been met.
13. Rhytidectomy is generally considered a cosmetic procedure. It may be considered medically necessary upon review 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.

LCD: Removal of Benign Skin Lesions (L35498); Effective date 10/01/15; Revision date: 10/28/21

This policy addresses the Medicare coverage for the removal of benign skin lesions, such as seborrheic keratoses, sebaceous (epidermoid) cysts and skin tags. Benign skin lesions are common in the elderly and are frequently removed at the patient's request to improve appearance. Removal of certain benign skin lesions that does not pose a threat to health or function, are considered **COSMETIC** and as such are not covered by the Medicare program.

A. Medical Indications

There may be instances in which the removal of non-malignant skin lesions is medically appropriate. Medicare will, therefore, consider their removal as medically necessary and not **COSMETIC**, if one or more of the following conditions are present and clearly documented in the medical record:

1. The lesion has one or more of the following characteristics: bleeding, itching, pain; change in physical appearance (reddening or pigmentary change), recent enlargement, increase in number; or
2. The lesion has physical evidence of inflammation, e.g., purulence, edema, erythema; or
3. The lesion obstructs an orifice; or
4. The lesion clinically restricts vision; or
5. There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on the lesion appearance; or
6. A prior biopsy suggests or is indicative of lesion malignancy; or
7. The lesion is in an anatomical region subject to recurrent trauma, and there is documentation of such trauma.
8. Wart removals will be covered under the guidelines listed above. In addition, wart destruction will be covered when any one of the following clinical circumstances is present:
   a. Periocular warts associated with chronic recurrent conjunctivitis thought secondary to lesion virus shedding.
   b. Warts showing evidence of spread from one body area to another, particularly in immunosuppressed patients.
   c. Lesions are condyloma acuminata or molluscum contagiosum.
   d. Cervical dysplasia or pregnancy is associated with genital warts.

LCD: Treatment of Varicose Veins of the Lower Extremities (L34536); Effective Date: 10/01/15; Revision Date: 9/30/2021

- The treatment of asymptomatic varicose veins, or symptomatic varicose veins without a 3-month trial of conservative measures, by any technique, will be considered COSMETIC and therefore not covered.
- The treatment of spider veins or superficial telangiectasis by any technique is also considered COSMETIC, and therefore not covered unless there is associatedbleeding.

Additional policy documents:
LCA: Billing and Coding: Cosmetic and Reconstructive Surgery (A58774) (Most recent version effective 11/14/2021)
LCA: Billing and Coding: Blepharoplasty, Blepharoptosis and Brow Lift (A56908) (Most recent version effective 04/30/2020)
LCA: Billing and Coding: Removal of Benign Skin Lesions (A57482) (Most recent version effective 10/28/2021).
LCA: Billing and Coding: Treatment of Varicose Veins of the Lower Extremities (A56914) (Most recent version effective 9/30/2021)

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

- N/A

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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 11/30/20, the date the research was completed.

Medical Policy History

Policy Effective Date	Comments
07/01/2021	Medical policy established
05/01/2021	Routine maintenance
11/14/2021	Updated LCD information

Next Review Date: 1st Qtr, 2022