# MN.006.I Cosmetic & Reconstructive Services

**Original Implementation Date** : 10/1/2007
**Version [I] Date :** 4/17/2024
**Last Reviewed Date:** April 2024

## PRODUCT VARIATIONS

This policy applies to all lines of business unless noted below.

☒**Medicare Variation**

For details regarding Medicare's exclusion of cosmetic procedures, refer to the Medicare Benefit Manual (Pub.100-2), Chapter 16, § 120 - Cosmetic Surgery. For additional details, see Policy Guidelines.

Related Medicare National Coverage Determinations (NCD) Manual (Pub 100-03)

- NCD 140.2 Breast Reconstruction Following Mastectomy
- NCD 250.5 Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS)
- NCD 140.4 Plastic Surgery to Correct "Moon Face"
- NCD 250.4 Treatment of Actinic Keratosis

Related Local Coverage Determination

- L35090 Cosmetic and Reconstructive Surgery
- L34938 Removal of Benign or Premalignant Skin Lesions
- L35004 Surgery: Blepharoplasty
- L34924-Treatment of Chronic Venous Insufficiency of the Lower Extremities

## POLICY STATEMENT



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We utilize the InterQual Procedures medical necessity criteria to determine the medical necessity of procedures addressed within the module. Where InterQual does not address a service, this policy applies.

### Differentiating Cosmetic and Reconstructive

A procedure is considered reconstructive and medically necessary if **BOTH** of the following apply:

1. Medical records show that the physical/physiological abnormality is causing functional impairment that requires correction. *(Functional impairment is defined below.*

2. The proposed treatment is proven safe and effective and is likely to improve or restore the patient's function.

A procedure is considered cosmetic and excluded from coverage if the condition is NOT associated with functional impairment and/or treatment does not correct or restore function (including a congenital abnormality). Socially avoidant behaviors do not classify a surgery as reconstructive.

- Repair of cleft lip and palate is considered reconstructive regardless of functional limitations.

### Chemical Peels

The following are considered **Medically Necessary:**

1. Dermal chemical peels used to treat patients with numerous (greater than 10) actinic keratoses or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical.

2. Epidermal chemical peels used to treat patients with active acne that has failed a trial of topical and/or oral antibiotic acne therapy. In this setting, superficial chemical peels with 50–70% alpha hydroxy acids are used as a comedolytic therapy. *(Alpha hydroxy acids can also be used in lower concentrations [8%] without the supervision of a physician).*

### Lipectomy

Lipectomy and liposuction for the excision/removal of excess skin and/or subcutaneous fat may be considered medically necessary when:

1. The excess skin/fat is causing functional impairment (such as pain, inability to perform activities of daily living, chronic rashes or skin ulceration).

2. The member has failed conservative treatments.

**TREATMENT OF BENIGN SKIN LESIONS**

Treatment of benign skin lesions may be considered medically necessary when one or more of the following criteria are met:

1. The lesion has one or more of the following characteristics:
    - Bleeding.
    - Change in appearance.
    - Itching.
    - Pain.
2. The lesion has physical evidence of inflammation or infection, e.g., purulence, oozing, edema, erythema, etc.
3. The lesion obstructs an orifice.
4. The lesion clinically restricts eye function. For example, the lesion:
    - Causes misdirection of eyelashes or eyelid.
    - Interferes with vision.
    - Restricts eyelid function.
    - Restricts lacrimal puncta and interferes with tear flow.
    - Touches the globe.
5. There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on lesion appearance.
6. A prior histological exam or biopsy suggests or is indicative of atypia (e.g., atypical nevus) or malignancy.
7. The lesion is in an anatomical region subject to recurrent physical trauma, and there is documentation that such trauma has occurred.
8. Wart removals will be covered under guidelines (1-7) above. In addition, wart destruction will be covered when any of the following clinical circumstances are present:
    a) Lesions are condyloma acuminata or molluscum contagiosum.
    b) Periocular warts associated with chronic recurrent conjunctivitis thought to be secondary to lesion virus shedding.
    c) Warts showing evidence of spread from one body area to another,

particularly in immunosuppressed individuals.

d) Cervical dysplasia or pregnancy is associated with genital warts.

**SERVICES/CONDITIONS GENERALLY CONSIDERED COSMETIC**

In general, the following conditions/procedures are considered cosmetic and not eligible under the Member's benefit plan:

- Birthmarks, blemishes.
- Botox for wrinkles.
- Breast augmentation/lift except when provided as part of post-mastectomy reconstructive services.
- Brow lift.
- Chemical peeling except when treating malignant or pre-malignant lesions.
- Collagen injections or implants.
- Dermabrasion (including treatment of acne scarring, but excluding the correction of defects from traumatic injury, surgery or disease).
- Diastasis recti repair.
- Electrolysis.
- Excision or repair of excess or sagging skin except Panniculectomy.
- Excisions of benign skin lesions and Moles/nevi (excluding suspicious or atypical moles/dysplastic nevi).
- Face lifts or related procedures to diminish the aging process.
- Fat grafts, unless an integral part of another covered procedure.
- Hair transplants or repair of any congenital or acquired hair loss, including hair analysis (except when performed following a burn injury, trauma, or tumor removal to correct hair loss related to the injury.
- Labial Hypertrophy.
- Laser facial resurfacing.
- Laser hair removal.
- Orthodontic treatment, even when provided along with reconstructive surgery.

- Otoplasty.
- Removal (any method) for excessive hair growth, even if caused by underlying medical condition.
- Rhinophyma treatment.
- Rhytidectomy (wrinkle removal).
- Salabrasion.
- Spider vein treatment.
- Tattoo removal.
- Torn ear lobe repair.

## POLICY GUIDELINES

Per DHS: any requests for services that do not meet criteria set in the PARP will be evaluated on a case-by-case basis."

In all cases, the appropriate documentation supporting medical necessity must be kept on file and, upon request, presented us.

The definition of medical necessity may vary by product due to state and federal regulatory requirements.

- Certain types of procedures require individual consideration to make a determination as to whether the service is cosmetic or reconstructive. Coverage may be dependent upon the cause and functional impairment associated with the condition.
    - *As an example*, a blepharoplasty may be cosmetic when vision is not impaired, but medically necessary if vision is impaired.
    - *As another example*, rhinoplasty is generally excluded from coverage when used to improve the shape of one's nose. However, if the nose was broken as a result of trauma and it impacts a person's ability to breathe, the service may be medically necessary. Preauthorization is required for procedures that are potentially cosmetic to allow individual consideration.
- Cosmetic surgery is performed on normal structures of the body primarily to improve appearance and/or self-esteem rather than to restore the anatomy and/or functions of the body that are lost or impaired due to an illness or injury. Cosmetic services are generally

excluded from coverage in all places of service within the Member's benefit document for all lines of business.

- Services that repair a defect that developed as a result of an injury or illness may be considered reconstructive. Reconstructive surgery is often performed on burn and accident victims. It may involve the rebuilding of fractured bones, as well as skin grafting. Reconstructive surgery includes procedures such as the reattachment of an amputated finger or toe or implanting a prosthesis. It is generally performed to improve function, but also attempts to approximate a normal appearance.

**Ambulatory Surgery Center:** Exclusion for plastic or cosmetic surgery for beautification purposes—for example, otoplasty for protruding ears or lop ears, rhinoplasty—except for internal nasal deformity—nasal reconstruction, excision of keloids, mammoplasty, silicone or silastic implants, dermabrasion, skin grafts and lipectomy. Plastic surgery is compensable if performed for the purpose of improving the functioning of a deformed body member.

**MEDICARE BENEFIT POLICY MANUAL CHAPTER 16, SECTION 120:** 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.

**PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES:** DHS defines Cosmetic Services and excludes them under Physician Services in 55 PA Code §1141.59(13), as an Inpatient in §1163.59(a)(5), and in an ASC under 1126.54(a)(9).

**Inpatient:** Plastic or cosmetic surgery for beautification purposes—for example, otoplasty for protruding ears or lop ears, rhinoplasty—except for internal nasal deformity—nasal reconstruction, excision of keloids, reduction mammoplasty, augmentation mammoplasty, silicone or silastic implants, fascioplasty, osteoplasty—prognathism and micrognathism—dermabrasion, skin grafts and lipectomy. For accidental injury, plastic surgery is compensable if performed for the purpose of improving the functioning of a deformed body member.

**Physician Services:** Cosmetic Surgery as defined in §1141.2(definitions) is listed as non-compensable. Cosmetic surgery — refers to a surgical procedure the primary purpose of which is to improve the appearance of the patient. The procedures include, but are not limited to, otoplasty for protruding ears or lop ears, rhinoplasty, except to correct internal nasal deformity, nasal reconstruction, excision of keloids, fascioplasty, osteoplasty for prognathism or micrognathism or both, dermabrasion, skin grafts and lipectomy.

# CODING

*Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.*

*CPT® is a registered trademark of the American Medical Association.*

| CPT Code | Description |
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| **10040** | ACNE SURGERY (EG, MARSUPIALLIZATION, OPENING OR REMOVAL OF MULTIPLE MILIA, COMEDONES, CYSTS, PUSTULES) |
| **11200** | REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; EACH ADDITIONAL 15 LESIONS, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) |
| **11201** | REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; EACH ADDITIONAL 10 LESIONS, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) |
| **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) |
| **11950** | SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 1 CC OR LESS |
| **11951** | SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 1.1 TO 5.0 CC |
| **11952** | SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 5.1 TO 10.0 CC |
| **11954** | SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); OVER 10.0 CC |
| **11960** | INSERTION OF TISSUE EXPANDER(S) FOR OTHER THAN BREAST, INCLUDING SUBSEQUENT EXPANSION |
| **11970** | REPLACEMENT OF TISSUE EXPANDER WITH PERMANENT PROSTHESIS |

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| **11971** | REMOVAL OF TISSUE EXPANDER(S) WITHOUT INSERTION OF PROSTHESIS |
| **15771** | GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO TRUNK, BREASTS, SCALP, ARMS, AND/OR LEGS; 50 CC OR LESS INJECTATE |
| **15772** | GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO TRUNK, BREASTS, SCALP, ARMS, AND/OR LEGS; EACH ADDITIONAL 50 CC INJECTATE, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) |
| **15773** | GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO FACE, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, AND/OR FEET; 25 CC OR LESS INJECTATE |
| **15774** | GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO FACE, EYELIDS, MOUTH, NECK, EARS, ORBITS, GENITALIA, HANDS, AND/OR FEET; EACH ADDITIONAL 25 CC INJECTATE, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) |
| **15775** | PUNCH GRAFT FOR HAIR TRANSPLANT; 1 TO 15 PUNCH GRAFTS |
| **15776** | PUNCH GRAFT FOR HAIR TRANSPLANT; MORE THAN 15 PUNCH GRAFTS |
| **15777** | IMPLANTATION OF BIOLOGIC IMPLANT (EG, ACELLULAR DERMAL MATRIX) FOR SOFT TISSUE REINFORCEMENT (EG, BREAST, TRUNK) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) |
| **15780** | DERMABRASION; TOTAL FACE (EG, FOR ACNE SCARRING, FINE WRINKLING, RHYTIDS, GENERAL KERATOSIS) |
| **15781** | DERMABRASION; SEGMENTAL, FACE |
| **15782** | DERMABRASION; REGIONAL, OTHER THAN FACE |
| **15783** | DERMABRASION; SUPERFICIAL, ANY SITE (EG, TATTOO REMOVAL) |
| **15786** | ABRASION; SINGLE LESION (EG, KERATOSIS, SCAR) |
| **15787** | ABRASION; EACH ADDITIONAL 4 LESIONS OR LESS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) |
| **15788** | CHEMICAL PEEL, FACIAL; EPIDERMAL |
| **15789** | CHEMICAL PEEL, FACIAL; DERMAL |
| **15792** | CHEMICAL PEEL, NONFACIAL; EPIDERMAL |
| **15793** | CHEMICAL PEEL, NONFACIAL; DERMAL |
| **15819** | CERVICOPLASTY |
| **15820** | BLEPHAROPLASTY, LOWER EYELID; |
| **15821** | BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED FAT PAD |
| **15822** | BLEPHAROPLASTY, UPPER EYELID |
| **15823** | BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN WEIGHTING DOWN LID |
| **15824** | RHYTIDECTOMY; FOREHEAD |
| **15825** | RHYTIDECTOMY; NECK WITH PLATYSMAL TIGHTENING (PLATYSMAL FLAP, P-FLAP) |

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| **15826** | RHYTIDECTOMY; GLABELLAR FROWN LINES |
| **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 |
| **15847** | EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY), ABDOMEN (EG, ABDOMINOPLASTY) (INCLUDES UMBILICAL TRANSPOSITION AND FASCIAL PLICATION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) |
| **15832** | EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); THIGH |
| **15833** | EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); LEG |
| **15834** | EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); HIP |
| **15835** | EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); BUTTOCK |
| **15836** | EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ARM |
| **15837** | EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); FOREARM OR HAND |
| **15838** | EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); SUBMENTAL FAT PAD |
| **15839** | EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); OTHER AREA |
| **15876** | SUCTION ASSISTED LIPECTOMY; HEAD AND NECK |
| **15877** | SUCTION ASSISTED LIPECTOMY; TRUNK |
| **15878** | SUCTION ASSISTED LIPECTOMY; UPPER EXTREMITY |
| **15879** | SUCTION ASSISTED LIPECTOMY; LOWER EXTREMITY |
| **17106** | DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); LESS THAN 10 SQ CM |
| **17107** | DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); 10.0 TO 50.0 SQ CM |
| **17108** | DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); OVER 50.0 SQ CM |
| **17110** | DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), OF BENIGN LESIONS OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; UP TO 14 LESIONS |
| **17111** | DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), OF BENIGN LESIONS OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PR |

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| | OLIFERATIVE LESIONS; 15 OR MORE LESIONS |
| **17250** | CHEMICAL CAUTERIZATION OF GRANULATION TISSUE (PROUD FLESH, SINUS OR FISTULA) |
| **17340** | CRYOTHERAPY (CO2 SLUSH, LIQUID N2) FOR ACNE |
| **17360** | CHEMICAL EXFOLIATION FOR ACNE (EG, ACNE PASTE, ACID) |
| **17380** | ELECTROLYSIS EPILATION, EACH 30 MINUTES |
| **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 |
| **19350** | NIPPLE/AREOLA 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 |
| **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 |
| **21083** | IMPRESSION AND CUSTOM PREPARATION; PALATAL LIFT PROTHESIS |
| **21085** | IMPRESSION AND CUSTOM PREPARATION; ORAL SURGICAL SPLINT |
| **21086** | IMPRESSION AND CUSTOM PREPARATION; AURICULAR PROSTHESIS |

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| **21087** | IMPRESSION AND CUSTOM PREPARATION; NASAL PROSTHESIS |
| **21088** | IMPRESSION AND CUSTOM PREPARATION; FACIAL PROSTHESIS |
| **21120** | GENIOPLASTY; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, PROSTHETIC MATERIAL) |
| **21121** | GENIOPLASTY; SLIDING OSTEOTOMY, SINGLE PIECE |
| **21122** | GENIOPLASTY; SLIDING OSTEOTOMIES, 2 OR MORE OSTEOTOMIES (EG, WEDGE EXCISION OR BONE WEDGE REVERSAL FOR ASYMMETRICAL CHIN) |
| **21123** | GENIOPLASTY; SLIDING, AUGMENTATION WITH INTERPOSITIONAL BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS) |
| **21125** | AUGMENTATION, MANDIBULAR BODY OR ANGLE; PROSTHETIC MATERIAL |
| **21127** | AUGMENTATION, MANDIBULAR BODY OR ANGLE; WITH BONE GRAFT, ONLAY OR INTERPOSITIONAL (INCLUDES OBTAINING AUTOGRAFT) |
| **21137** | REDUCTION FOREHEAD; CONTOURING ONLY |
| **21138** | REDUCTION FOREHEAD; CONTOURING AND APPLICATION OF PROSTHETIC MATERIAL OR BONE GRAFT (INCLUDES OBTAINING AUTOGRAFT) |
| **21139** | REDUCTION FOREHEAD; CONTOURING AND SETBACK OF ANTERIOR FRONTAL SINUS WALL |
| **21141** | RECONSTRUCTION MIDFACE, LEFORT I; SINGLE PIECE, SEGMENT MOVEMENT IN ANY DIRECTION (EG, FOR LONG FACE SYNDROME), WITHOUT BONE GRAFT |
| **21142** | RECONSTRUCTION MIDFACE, LEFORT I; 2 PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, WITHOUT BONE GRAFT |
| **21143** | RECONSTRUCTION MIDFACE, LEFORT I; 3 OR MORE PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, WITHOUT BONE GRAFT |
| **21145** | RECONSTRUCTION MIDFACE, LEFORT I; SINGLE PIECE, SEGMENT MOVEMENT IN ANY DIRECTION, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS) |
| **21146** | RECONSTRUCTION MIDFACE, LEFORT I; 2 PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS) (EG, UNGRAFTED UNILATERAL ALVEOLAR CLEFT) |
| **21147** | RECONSTRUCTION MIDFACE, LEFORT I; 3 OR MORE PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS) (EG, UNGRAFTED BILATERAL ALVEOLAR CLEFT OR MULTIPLE OSTEOTOMIES) |
| **21150** | RECONSTRUCTION MIDFACE, LEFORT II; ANTERIOR INTRUSION (EG, TREACHER-COLLINS SYNDROME) |
| **21151** | RECONSTRUCTION MIDFACE, LEFORT II; ANTERIOR INTRUSION (EG, TREACHER-COLLINS SYNDROME) |
| **21188** | RECONSTRUCTION MIDFACE, OSTEOTOMIES (OTHER THAN LEFORT TYPE) AND BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS) |
| **21193** | RECONSTRUCTION OF MANDIBULAR RAMI, HORIZONTAL, VERTICAL, C, OR L OSTEOTOMY; WITHOUT BONE GRAFT |

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| **21194** | RECONSTRUCTION OF MANDIBULAR RAMI, HORIZONTAL, VERTICAL, C, OR L OSTEOTOMY; WITH BONE GRAFT (INCLUDES OBTAINING GRAFT) |
| **21195** | RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITHOUT INTERNAL RIGID FIXATION |
| **21196** | RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITH INTERNAL RIGID FIXATION |
| **21198** | OSTEOTOMY, MANDIBLE, SEGMENTAL |
| **21199** | OSTEOTOMY, MANDIBLE, SEGMENTAL; WITH GENIOGLOSSUS ADVANCEMENT |
| **21206** | OSTEOTOMY, MAXILLA, SEGMENTAL (EG, WASSMUND OR SCHUCHARD) |
| **21208** | OSTEOPLASTY, FACIAL BONES; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, OR PROSTHETIC IMPLANT) |
| **21209** | OSTEOPLASTY, FACIAL BONES; REDUCTION |
| **21210** | GRAFT, BONE; NASAL, MAXILLARY OR MALAR AREAS (INCLUDES OBTAINING GRAFT) |
| **21215** | GRAFT, BONE; MANDIBLE (INCLUDES OBTAINING GRAFT) |
| **21230** | GRAFT; RIB CARTILAGE, AUTOGENOUS, TO FACE, CHIN, NOSE OR EAR (INCLUDES OBTAINING GRAFT) |
| **21235** | GRAFT; EAR CARTILAGE, AUTOGENOUS, TO NOSE OR EAR (INCLUDES OBTAINING GRAFT) |
| **21270** | MALAR AUGMENTATION, PROSTHETIC MATERIAL |
| **21275** | SECONDARY REVISION OF ORBITOCRANIOFACIAL RECONSTRUCTION |
| **21280** | MEDIAL CANTHOPEXY (SEPARATE PROCEDURE) |
| **21282** | LATERAL CANTHOPEXY |
| **26590** | REPAIR MACRODACTYLIA, EACH DIGIT |
| **30120** | EXCISION OR SURGICAL PLANING OF SKIN OF NOSE FOR RHINOPHYMA |
| **30400** | RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR ELEVATION OF NASAL TIP |
| **30410** | RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL PARTS INCLUDING BONY PYRAMID, LATERAL AND ALAR CARTILAGES, AND/OR ELEVATION OF NASAL TIP |
| **30420** | RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPTAL REPAIR |
| **30430** | RHINOPLASTY, SECONDARY; MINOR REVISION (SMALL AMOUNT OF NASAL TIP WORK) |
| **30435** | RHINOPLASTY, SECONDARY; INTERMEDIATE REVISION (BONY WORK WITH OSTEOTOMIES) |
| **30450** | RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK AND OSTEOTOMIES) |
| **30460** | RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO CONGENITAL CLEFT LIP AND/OR PALATE, INCLUDING COLUMELLAR LENGTHENING; TIP ONLY |
| **30462** | RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO CONGENITAL CLEFT LIP AND/OR PALATE, INCLUDING COLUMELLAR LENGTHENING; TIP, SEPTUM, OSTEOTOMIES |

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| **30465** | REPAIR OF NASAL VESTIBULAR STENOSIS (EG, SPREADER GRAFTING, LATERAL NASAL WALL RECONSTRUCTION) |
| **30520** | SEPTOPLASTY OR SUBMUCOUS RESECTION, WITH OR WITHOUT CARTILAGE SCORING, CONTOURING OR REPLACEMENT WITH GRAFT |
| **30620** | SEPTAL OR OTHER INTRANASAL DERMATOPLASTY (DOES NOT INCLUDE OBTAINING GRAFT) |
| **31830** | REVISION OF TRACHEOSTOMY SCAR |
| **36468** | SINGLE OR MULTIPLE INJECTIONS OF SCLEROSING SOLUTIONS, SPIDER VEINS (TELANGIECTASIA); LIMB OR TRUNK |
| **36470** | INJECTION OF SCLEROSANT; SINGLE INCOMPETENT VEIN (OTHER THAN TELANGIECTASIA) |
| **36471** | INJECTION OF SCLEROSANT; MULTIPLE INCOMPETENT VEINS (OTHER THAN TELANGIECTASIA) SAME LEG |
| **37785** | LIGATION, DIVISION, AND/OR EXCISION OF VARICOSE VEIN CLUSTER(S), 1 LEG |
| **43644** | LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND ROUX-EN-Y GASTROENTEROSTOMY (ROUX LIMB 150 CM OR LESS) |
| **43645** | LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND SMALL INTESTINE RECONSTRUCTION TO LIMIT ABSORPTION |
| **43770** | LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; PLACEMENT OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE (EG, GASTRIC BAND AND SUBCUTANEOUS PORT COMPONENTS) |
| **43771** | LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REVISION OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE COMPONENT ONLY |
| **43772** | LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE COMPONENT ONLY |
| **43773** | LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL AND REPLACEMENT OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE COMPONENT ONLY |
| **43774** | LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE AND SUBCUTANEOUS PORT COMPONENTS |
| **43775** | LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; LONGITUDINAL GASTRECTOMY (IE, SLEEVE GASTRECTOMY) |
| **43842** | GASTRIC RESTRICTIVE PROCEDURE, WITHOUT GASTRIC BYPASS, FOR MORBID OBESITY; VERTICAL-BANDED GASTROPLASTY |
| **43843** | GASTRIC RESTRICTIVE PROCEDURE, WITHOUT GASTRIC BYPASS, FOR MORBID OBESITY; OTHER THAN VERTICAL-BANDED GASTROPLASTY |
| **43845** | GASTRIC RESTRICTIVE PROCEDURE WITH PARTIAL GASTRECTOMY, PYLORUS-PRESERVING DUODENOILEOSTOMY AND ILEOILEOSTOMY (50 TO 100 CM COMMON CHANNEL) TO LIMIT ABSORPTION (BILIOPANCREATIC DIVERSION WITH DUODENAL SWITCH) |
| **43846** | GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR MORBID OBESITY; WITH SHORT LIMB (150 CM OR LESS) ROUX-EN-Y GASTROENTEROSTOMY |

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| **43847** | GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR MORBID OBESITY; WITH SMALL INTESTINE RECONSTRUCTION TO LIMIT ABSORPTION |
| **43848** | REVISION, OPEN, OF GASTRIC RESTRICTIVE PROCEDURE FOR MORBID OBESITY, OTHER THAN ADJUSTABLE GASTRIC RESTRICTIVE DEVICE (SEPARATE PROCEDURE) |
| **43886** | GASTRIC RESTRICTIVE PROCEDURE, OPEN; REVISION OF SUBCUTANEOUS PORT COMPONENT ONLY |
| **43887** | GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL OF SUBCUTANEOUS PORT COMPONENT ONLY |
| **43888** | GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL AND REPLACEMENT OF SUBCUTANEOUS PORT COMPONENT ONLY |
| **49250** | UMBILECTOMY, OMPHALECTOMY, EXCISION OF UMBILICUS (SEPARATE PROCEDURE) |
| **54161** | CIRCUMCISION, SURGICAL EXCISION OTHER THAN CLAMP, DEVICE, OR DORSAL SLIT; OLDER THAN 28 DAYS OF AGE |
| **54660** | INSERTION OF TESTICULAR PROSTHESIS (SEPARATE PROCEDURE) |
| **56620** | VULVECTOMY SIMPLE; PARTIAL |
| **56625** | VULVECTOMY SIMPLE; COMPLETE |
| **56805** | CLITOROPLASTY FOR INTERSEX STATE |
| **57291** | CONSTRUCTION OF ARTIFICIAL VAGINA; WITHOUT GRAFT |
| **57292** | CONSTRUCTION OF ARTIFICIAL VAGINA; WITH GRAFT |
| **57295** | REVISION (INCLUDING REMOVAL) OF PROSTHETIC VAGINAL GRAFT; VAGINAL APPROACH |
| **57296** | REVISION (INCLUDING REMOVAL) OF PROSTHETIC VAGINAL GRAFT; OPEN ABDOMINAL APPROACH |
| **57335** | VAGINOPLASTY FOR INTERSEX STATE |
| **65760** | KERATOMILEUSIS |
| **65765** | KERATOPHAKIA |
| 65767 | EPIKERATOPLASTY |
| **65771** | RADIAL KERATOTOMY |
| **67900** | REPAIR OF BROW PTOSIS (SUPRACILIARY, MID-FOREHEAD OR CORONAL APPROACH) |
| **67901** | REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH SUTURE OR OTHER MATERIAL (EG, BANKED FASCIA) |
| **67902** | REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH AUTOLOGOUS FASCIAL SLING (INCLUDES OBTAINING FASCIA) |
| **67903** | REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, INTERNAL APPROACH |
| **67904** | REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, EXTERNAL APPROACH |

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| **67906** | REPAIR OF BLEPHAROPTOSIS; SUPERIOR RECTUS TECHNIQUE WITH FASCIAL SLING (INCLUDES OBTAINING FASCIA) |
| **67908** | REPAIR OF BLEPHAROPTOSIS; CONJUNCTIVO-TARSO-MULLER'S MUSCLE-LEVATOR RESECTION (EG, FASANELLA-SERVAT TYPE) |
| **67909** | REDUCTION OF OVERCORRECTION OF PTOSIS |
| **67911** | CORRECTION OF LID RETRACTION |
| **67923** | REPAIR OF ENTROPION; EXCISION TARSAL WEDGE |
| **67950** | CANTHOPLASTY (RECONSTRUCTION OF CANTHUS) |
| **69090** | EAR PIERCING |
| **69300** | OTOPLASTY, PROTRUDING EAR, WITH OR WITHOUT SIZE REDUCTION |

| HCPCS Code | Description |
|---|---|
| **A9282** | WIG ANY TYPE, EACH |
| **C1789** | PROSTHESIS, BREAST (IMPLANTABLE) |
| **C9160** | INJECTION, DAXIBOTULINUMTOXINA-LANM, 1 UNIT |
| **C9784** | GASTRIC RESTRICTIVE PROCEDURE, ENDOSCOPIC SLEEVE GASTROPLASTY, WITH ESOPHAGOGASTRODUODENOSCOPY AND INTRALUMINAL TUBE INSERTION, IF PERFORMED, INCLUDING ALL SYSTEM AND TISSUE ANCHORING COMPONENTS |
| **C9785** | ENDOSCOPIC OUTLET REDUCTION, GASTRIC POUCH APPLICATION, WITH ENDOSCOPY AND INTRALUMINAL TUBE INSERTION, IF PERFORMED, INCLUDING ALL SYSTEM AND TISSUE ANCHORING COMPONENTS |
| **J0585** | INJECTION, ONABOTULINUMTOXINA, 1 UNIT |
| **J0586** | INJECTION, ABOBOTULINUMTOXINA, 5 UNITS |
| **J0587** | INJECTION, RIMABOTULINUMTOXINB, 100 UNITS |
| **J0588** | INJECTION, INCOBOTULINUMTOXINA, 1 UNIT |
| **J0589** | Injection, daxibotulinumtoxina-lanm, 1 unit |
| **L8600** | IMPLANTABLE BREAST PROSTHESIS, SILICONE OR EQUAL |
| **Q4100** | SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED |
| **S0800** | LASER IN SITU KERATOMILEUSIS (LASIK) |

| ICD 10 Codes | Description |
|---|---|
| N/A | N/A |

## BENEFIT APPLICATION

Medical policies do not constitute a description of benefits. This medical necessity policy assists in the administration of the member's benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage. This policy is invoked only when the requested service is an eligible benefit as defined in the Member's applicable benefit contract on the date the service was rendered. Services determined by the Plan to be investigational or experimental, cosmetic, or not medically necessary are excluded from coverage for all lines of business.

## DESCRIPTION OF SERVICES

This policy describes considerations in determining when services are cosmetic.

## DEFINITIONS

**Cosmetic Surgery:** Surgery performed to reshape normal structure of the body in order to improve the patient's appearance and self-esteem.

**Functional impairment:** Functional impairment is a deviation from the normal utility of a tissue, organ, or body part. It results in a significantly limited, impaired, or delayed ability to move, coordinate actions, or performs physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

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

# DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making.

Policy Bulletins are developed by us to assist in administering plan benefits and constitute neither offers of coverage nor medical advice.

This Policy Bulletin may be updated and therefore is subject to change.

Per DHS Medicaid and CHIP products: Any requests for services that do not meet criteria set in PARP will be evaluated on a case-by-case basis.

# POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

| Summary | Version | Effective Date |
|---|---|---|
| 2024 Annual review. Language added related to wart removals. Code J0589 was added. | I | 4/17/2024 |
| 7/1/23 Code update. C9784 & C9785 were added. | H | 9/1/2023 |
| 2023 Annual review. No changes. Reissue as written. | G | 10/15/2021 |
| 2022 Annual review. Product Variations section updated to include: L34924-Treatment of Chronic Venous Insufficiency of the Lower Extremities. References section updated. No other changes to policy content. | G | 10/15/2021 |
| 2021 ad hoc review. The following codes were removed from the coding table: 11400, 11401, 11402, 11403, 11404, 11406, 11420, 11421, 11422, 11423, 11424, 11426, 11440, 11441, 11442, 11443, 11444, 11446. | G | 10/15/2021 |
| 2021 Annual policy review. No changes to the policy language. The following codes are no longer active and were removed from the coding table: 19324, 19366, 36469. | F | 5/1/2020 |
| 2020 Annual policy review. The following codes were added to the coding table: 15771, 15772, 15773, 15774. | F | 5/1/2020 |

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|---|---|---|
| 2019 Annual policy review. Policy language remains the same. Reissue for 2019. | E | 11/1/2018 |
| 2018 Annual policy review. Septoplasty and circumcision removed from prior authorization, but codes 30520 & 54161 will remain in the policy. | E | 11/1/2018 |
| Photodynamic Therapy codes (96567, 96573, and 96574) have been removed because they are now covered for certain indications. | D | 1/1/2018 |
| ▪ Policy revised to remove the deleted code: 36469.<br>▪ Codes 54406, 54408, and 54415 were removed based on NCD 230.4 Diagnosis and Treatment of Impotence which now considers the service medically necessary when criteria are met.<br>▪ Prior authorization requirements for 17110 and 17111 removed from guideline section. | C | 10/13/2016 |
| ▪ Codes considered potentially cosmetic in Claim Check Edit added to policy for consistency (10040, 21083, 67911, S0800).<br>▪ No change in coverage criteria.<br>▪ Language in Guideline section for benign skin lesions (17110, 17111) added to policy. | B | 8/1/2016 |
| New Policy. | A | 7/27/2016 |

## REFERENCES

1) Centers for Medicare & Medicaid Services (CMS) **Medicare Benefit Manual (Pub.100-2), Chapter 16**, § 120 - Cosmetic Surgery; **CMS.gov Medicare Benefit Policy Manual Chapter 16**

2) Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD) **NCD 140.2** - Breast Reconstruction Following Mastectomy. https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=64&ncdver=1&bc=AAAAgAAAAAAAAA%3d%3d&

3) Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD) **NCD 250.5** Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=338&ncdver=1&bc=AAAAgAAAAAAAAA%3d%3d&

4) Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD) **NCD 140.4** - Plastic Surgery to Correct "Moon Face". https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=14&ncdver=1&bc=AAAAgAAAAAAAAA%3d%3d&

5) Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD) **NCD 250.4** - Treatment of Actinic Keratosis **https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=129&ncdver=1&bc=AAAAgAAAAAAAAA%3d%3d&**

6) Novitas Solutions, Local Coverage Determination (LCD) **L35090** Cosmetic and Reconstructive Surgery. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=35090&ver=95&bc=0

7) Novitas Solutions, Local Coverage Determination (LCD) - **L34938** - Removal of Benign or Premalignant Skin Lesions. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=34938&ver=68&bc=0

8) Novitas Solutions, Local Coverage Determination (LCD) **L35004** - Surgery: Blepharoplasty: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=35004&ver=23&bc=0

9) Novitas Solutions, Local Coverage Determination (LCD) **L34924** Treatment of Chronic Venous Insufficiency of the Lower Extremities https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34924

10) Pennsylvania Code. § 1163.59. Noncompensable services, items, and outlier days. **The Pennsylvania CODE Noncompensable Services, items, and outlier days**