Clinical Policy: Cosmetic and Reconstructive Surgery

Reference Number: CA.CP.MP.169
Effective Date: 10/04
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Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Medicare	LCD L39051	https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39051&ver=5&

Description
Medical necessity criteria for cosmetic or reconstructive surgery. Please note that these are subject to state and federal mandates as well as member benefits and evidence of coverage guidelines. Please refer to the reconstructive surgery mandates for California for more detail.

Not all cosmetic procedures are listed in this policy. The Medical Director has the final decision to deny coverage for services deemed cosmetic in nature and not medically necessary.

Policy/Criteria

I. It is the policy of California Health & Wellness that reconstructive surgery is **medically necessary** for any of the following indications:

A. Surgery to correct congenital defects that cause significant functional deficiencies or challenges of any body part, developmental abnormalities, degeneration defects, trauma, infections, tumors or disease
B. Facial surgery to correct congenital, acquired, traumatic, or developmental anomalies that may not result in functional impairment, bur are so severely disfiguring as to merit consideration for corrective surgery (e.g. the craniofacial anomalies associated with Crouzon's Syndrome and Treacher-Collins Syndrome etc)
C. Surgery in connection with treatment of severe burns.
D. Surgery for therapeutic purposes which coincidentally also serve some cosmetic purpose
E. Insertion or injection of prosthetic material for significant deformity from disease or trauma
F. Pulsed dye laser therapy for the treatment of proliferative vascular disorders such as congenital port wine stains of the face or neck
G. The intense pulsed light sources (IPLS; e.g., PhotoDerm VL) for medically appropriate treatment of congenital port wine stains when there is documented evidence of failure of treatment with pulsed dye laser therapy
H. Excision/treatment of tattoos of traumatic or therapeutic origins
I. Surgical treatment of congenital hemangiomas when any of the following are met:
   1. The hemangioma is interfering with the functionality of the nose, eyes, ears, lips or larynx;
   2. The hemangioma is symptomatic (e.g., bleeding, painful, ulcerated, recurrent infection); or
   3. The hemangioma is associated with Kasaback-Merritt Syndrome;

4.The hemangioma is pedunculated

J. Repair/revision of scars, including keloids, originating from a covered surgical or therapeutic procedure or an accidental injury that are associated with significant symptoms of pain, burning or itching which cannot effectively be treated with non-narcotic analgesics and/or steroid injections, that interferes with normal bodily function such as the movement of a joint, or are unstable and have a history of intermittent breakdown

K. Low-dose radiation (superficial or interstitial) as an adjunctive therapy immediately following excisional surgery (within 7 days) in the treatment of keloids when criteria for keloid removal are met

L. Testicular prostheses for replacement of congenitally absent testes, or testes lost due to disease, injury, or surgery

M. Excision of lipoma(s) when located in an area(s) of repeated touch or pressure with documentation of tenderness and/or inhibition of the patient's ability to perform activities of daily living

N. Skin tag removal when located in an area of friction with documentation of repeated irritation and bleeding

O. External facial prosthesis when there is loss or absence of facial tissue due to disease, trauma, surgery, or a congenital defect, regardless of whether or not the facial prosthesis restores function

P. Chin, cheek, or jaw reshaping (facial implants or soft tissue augmentation) for deformities of the maxilla or mandible resulting from trauma or disease and to be distinguished from orthognathic surgery

Q. Punch graft hair transplant may be considered reconstructive when it is performed to correct permanent hair loss that is clearly caused by disease or injury (e.g., eyebrow(s) replacement following a burn injury or tumor removal as in craniotomy).

R. Otoplasty (ear pinning) for absent or deformed ears such as microtia (small, abnormally shaped or absent external ears) or anotia (total absence of the external ear and auditory canal) with functional deficiencies resulting from trauma, surgery, disease or congenital defect when performed to improve hearing by directing sound into the ear canal.

S. Post-mastectomy or post significant lumpectomy resulting in asymmetry: breast reconstruction, including nipple reconstruction, tattooing and surgery on contralateral breast to restore symmetry;

T. Removal of a breast implant, periprosthetic capsulotomy or capsulectomy for mechanical complications of breast prosthesis such as rupture, extrusion, painful capsular contracture with disfigurement, inflammatory reaction to implant, siliconoma, granuloma, interference with diagnosis of breast cancer

U. Breast implant for Poland's syndrome (congenital absence of breast)

V. Repair of breast asymmetry due to trauma.

W. Use of FDA-approved facial dermal injections (Sculptra™, Radiesse®) or autologous fat transfers for HIV-associated wasting for facial lipodystrophy syndrome (FLS)

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II. It is the policy of California Health & Wellness that cosmetic surgery is **not medically necessary** and generally not a covered benefit when performed to improve a patient's normal appearance and self-esteem. (Note that there may be exceptions when procedures are related to gender dysphoria treatment.) These procedures include, but are not limited to:

A. Cosmetic surgery performed purely for the purpose of enhancing one's appearance, and/or expenses incurred in connection with such surgery
B. Cosmetic surgery performed to treat psychiatric or emotional distress, problems or disorders
C. Dermabrasion, chemical peel, liquid nitrogen, skin grafting, dry ice or CO2 snow unless otherwise specified
D. Flesh color tattooing for the treatment of port wine stains, hemangiomas or birth marks
E. The intense pulsed light sources (IPLS; e.g., PhotoDerm VL) as initial therapy for treatment of proliferative vascular disorders such as port wine stains, hemangiomas, spider angiomas, cherry angiomas and facial telangiectasias
F. Septoplasty performed solely to improve the patient's appearance in the absence of any signs and/or symptoms of functional respiratory abnormalities
G. Rhinoplasty for external nasal deformity not due to trauma or disease (non covered services)
H. Mastopexy (breast lift) to treat sagging of the breast unless otherwise specified
I. Removal or revision of a breast implant for non-medical reasons
J. Surgery to correct a condition of "moon face" which developed as a side effect of cortisone therapy
K. Otoplasty (ear pinning) for lop ears, bat ears or prominent or protruding ears without
L. Injection of any filling material (collagen) including but not limited to collagen, fat or other autologous or foreign material grafts unless treatment for facial lypodystrophy
M. Salabrasion
N. Rhytidectomy of face (face lift) for aging skin
O. Removal of fatty tissue by lipectomy (i.e. suction-assisted liposuction, lipoplasty) unless otherwise specified
P. Excision excessive skin, thigh, leg, hip, buttock, arm, forearm or hand, submental fat pad, other areas unless otherwise specified
Q. Electrolysis or laser hair removal unless specified (ie gender affirming procedures)
R. Correction of inverted nipples
S. Sclerosing of spider veins and/or telangiectasis
T. Excision/correction of glabellar frown lines
U. Hair transplants to correct male pattern baldness (alopecia) or age related hair thinning in women
V. Ear piercing
W. Facial rejuvenation/plumping/collagen or fat injections
X. Buttock or thigh lifts
Y. Neck Tucks
Z. Chin implant to improve ones appearance
AA. Epidural chemical peels used to photoaged skin, wrinkles, or acne scarring
BB. Cryotherapy for acne

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CC. Dermal chemical peel used as treatment of end-stage acne scarring
DD. Dermabrasion for wrinkling, pigmentation or severe acne scarring
EE. Chemical exfoliation for acne
FF. Laser Resurfacing for wrinkling, aging skin or telangectasias from rosacea
GG. Insertion or injection of prosthetic material to replace absent adipose tissue
HH. Augmentation or enlargement (augmentation Mammoplasty) of small but otherwise normal breasts unless part of gender affirming surgery
II. Phalloplasty (penis enlargement)
JJ. Diastasis recti repair in the absence of a true midline hernia without evidence of current or potential incarceration, volvulus, or strangulation of bowel
KK. Excision/treatment of decorative tattoos
LL. Repair/revision of vaccination scars
MM. Reduction of labia minor
NN. Collagen implant (e.g. Zyderm)
OO. Earlobe repair to close a stretched pierce hole
PP. Surgery to change the appearance of a child with Downs Syndrome
QQ. Vestibuloplasty
RR. Vermilionectomy (lip shave) with mucosal advancement

Background

Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, previous or concurrent surgeries, trauma, infection, tumors or disease. It is generally performed to improve the functioning of a body part and may or may not restore a normal appearance. Functional impairment is a health condition in which the normal function of a part of the body or organ system is less than age appropriate at full capacity, such as decreased range of motion, diminished eyesight or hearing, etc. that variably impacts activities of daily living.

Cosmetic surgery is performed to reshape normal structures of the body in order to improve the appearance and self-esteem of a patient. It is generally not considered medically necessary. This policy will provide general guidelines as to when cosmetic and reconstructive surgery is or is not medically necessary.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2015, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

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Codes related to this policy: May not be an all inclusive list

CPT® Codes	Description
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11300-11313	Shaving of epidermal or dermal lesions
11400-11446	Excision of benign lesions
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 or filling material (e.g collagen); 1 cc or less
11951	Subcutaneous injection or filling material (e.g., collagen); 1.1 cc to 5.0 cc
11952	Subcutaneous injection or filling material (e.g., collagen); 5.1 cc to 10.0 cc
11954	Subcutaneous injection or filling material (e.g., collagen); over 10.0 cc
11960	Insertion of tissue expander(s)for other than breast, including subsequent expansion
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion, total face (e.g. for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion, segmental, face
15782	Dermabrasion, regional, other than face
15783	Dermabrasion, superficial, any site (e.g.tattoo removal)
15786	Abrasion; single lesion (e.g. keratosis, scar)
15787	Abrasion; each additional 4 lesions or less
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid with excessive skin weighing down lid
15824-15829	Rhytidectomy

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CPT® Codes	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g. abdominoplasty) (includes umbilical transposition and fascial placation
17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm
17107	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq cm
17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq cm
17250	Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)
17380	Electrolysis epilation, each 30 minutes
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)
30420	Rhinoplasty, primary; including major septal repair
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary, major revision (bony 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
30520	Septoplasty or submucous resection, with or without cartilage scorring, contouring or replacement with graft
40500	Vermilionectomy (lip shave), with mucosal advancement.
40840	Vestibuloplasty; anterior
40842	Vestibuloplasty; posterior, unilateral
40843	Vestibuloplasty; posterior, bilateral
40844	Vestibuloplasty; entire arch
40845	Vestibuloplasty; complex (including ridge extension, muscle repositioning)
69300	Otoplasty, protruding ear, with or withoutsize reduction
96999	Unlisted special dermatological service or procedure

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

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ICD-10-CM Code	Description
L30.4	Erythema intertrigo
M95.4	Acquired deformity of chest and rib
Q16.0-Q16.9	Congenital malformations of ear causing impairment of hearing
Q17.2	Microtia
Q67.6	Pectus excavatum
Q75.1	Crouzon's Syndrome
Q75.4	Treacher-Collins Syndrome
Q79.8	Poland syndrome
Q82.5	Congenital non-neoplastic nevus
D17.0-D17.9	Benign lipomatous neoplasm
D18.01	Hemangioma of skin and subcutaneous tissue
H02.401-H02.439	Ptosis of eyelid
L90.5	Scar condition and fibrosis of skin
L91.0	Hypertrophic scar
L91.8	Other hypertrophic disorders of the skin
Q55.0	Absence and aplasia of testis
Z85.3	Personal history of malignant neoplasm of breast
Z90.01	Acquired absence of eye
Z90.10-Z90.13	Acquired absence of breast and nipple

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted from Health Net NMP169 Cosmetic and Reconstructive Surgery	12/16	
Annual review, no changes	11/17	
Added language to refer to California reconstructive surgery mandates and also noted that for the treatment of gender dysphoria, there may be exceptions to some procedures generally considered cosmetic. Added references	11/18	11/18
Removed Nasal Surgery (S) and section on pectus excavatum (T) and Nuss procedure (U) from medically necessary section since all have Interqual criteria	11/19	11/19
Added W to medically necessary section – treatment for facial lipodystrophy	05/20	05/20
Reviewed, no changes	11/20	11/20
Reviewed, no changes	10/21	10/21
Annual review; updated codes no major changes	10/22	10/22
Annual review, no changes	10/23	10/23

References

1. California Health and Safety Code 1367.63 requires health care service plans to cover reconstructive surgery. "Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

   (1) To improve function or
   (2) To create a normal appearance, to the extent possible.

   California Health and Safety Code 1367.6 requires treatment for breast cancer to cover prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy

2. American Society of Plastic And Reconstructive Surgeons. Position Paper. Breast Reconstruction. June 1999.
3. American Society of Plastic and Reconstructive Surgeons. Position Paper. Cutaneous Laser Surgery. January 1999.
4. American Society of Plastic and Reconstructive Surgeons. Position Paper, Ear Deformity: Prominent Ears. January 1998.
5. American Society of Plastic and Reconstructive Surgeons. Position Paper, Reoperation of Women with Breast Implants. June 1994.
6. Institute for Clinical Systems Improvement (ISCI). Acne management. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2003.
7. Hayes. Health Technology Brief. Nuss Procedure for Pectus Excavatum in Children. December 31, 2010. Archived Jan 2014
8. National Institute for Health and Clinical Excellence (NICE). Placement of pectus bar for pectus excavatum (also known as MIRPE or the Nuss procedure). August 26, 2009..
9. American Society of Plastic Surgeons (ASPS): Recommended Insurance Coverage Criteria for Third-Party Payers; Abdominoplasty and Panniculectomy Unrelated to Obestiy or Massive Weight Loss. Available at:https://www.plasticsurgery.org/Documents/medical-professionals/health-policy/insurance/Abdominoplasty-and-Panniculectomy.pdf
10. American Society of Plastic Surgeons. Physician's guide to cosmetic surgery overview.
11. DeLong MR, Tandon VJ, Rudkin GH, Da Lio AL. Latissimus Dorsi Flap Breast Reconstruction-A Nationwide Inpatient Sample Review. Ann Plast Surg. 2017 Mar 24.
12. Goldstein BG, Goldstein AO. Keloids and hypertrophic scars. In: UpToDate. Dellaville RP, Levy ML (Ed), UpToDate, Waltham, MA. Accessed 3/13/18.
13. Razdan SN, Cordeiro PG, Albornoz CR, et al. National Breast Reconstruction Utilization in the Setting of Postmastectomy Radiotherapy. J Reconstr Microsurg. 2017 Feb 24
14. Ilonzo N, Tsang A, Tsantes S, et al. Breast reconstruction after mastectomy: A ten-year analysis of trends and immediate postoperative outcomes. Breast. 2017 Apr;32:7-12. doi: 10.1016/j.breast.2016.11.023. Epub 2016 Dec 16.
15. California Health and Safety Code 1367.63 and California Insurance Code 10123.88

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16. CMS: National Coverage Determination (NCD) for Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (250.5)
17. Liu C, Li MK, Alster TS, et al. Alternative cosmetic and medical applications of injectable deoxycholic acid: A systematic review. Dermatol Surg. 2021;47(11):1466-1472.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.