MN.006.F	Cosmetic & Reconstructive Services

Health Partners Plans

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PRODUCT VARIATIONS

This policy applies to all HealthPartners Plans (HPP) product lines 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

Where Medicare coverage documents address services/conditions, they supersede this policy.

Mandate: The treatment of congenital birth anomalies of newborn children is a mandated benefit for members in Pennsylvania, Delaware, and New Jersey, and is covered under the medical benefits of Health Partners Plans products for 31 days after birth. After 31 days, the infant must be enrolled as a dependent child in order to be covered under the medical benefits of the Company's products.

***NOTE**: This policy only applies when a specific HPP medical necessity policy addressing the item/service does not exist. For Medicare products, Medicare guidance documents (Internet-only manuals, national and local coverage determinations) supersede this policy.*

POLICY STATEMENT

Health Partners Plan utilizes 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 Lesionss

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) Periocular warts associated with chronic recurrent conjunctivitis thought to be secondary to lesion virus shedding
   b) Warts showing evidence of spread from one body area to another
   c) Lesions are condyloma acuminata
   d) Removal of molluscum contagiosum
   e) Benign epidermal or pilar cyst with history of infection, drainage, or multiple ruptured cysts
   f) Destruction of actinic keratosis

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
- 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
- Excisions of benign skin lesions and Moles/nevi (excluding suspicious or atypical moles/dysplastic nevi)
- 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

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

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 Health Partners Plans 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.[4]

Medicare Benefit Policy Manual Chapter 16, Section 120: Cosmetic surgery or expenses incurred 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 medical 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.[1]

Pennsylvania Department of Human Services: DHS defines cosmetic services and excludes them under Physican 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.[4]

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.[4]

CODING

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 Code	Description
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

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)
11400	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE),
11401	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE),
11402	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 1.1 TO 2.0 CM
11403	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 2.1 TO 3.0 CM
11404	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 3.1 TO 4.0 CM
11406	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER OVER 4.0 CM
11420	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 0.5 CM OR LESS
11421	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 0.6 TO 1.0 CM
11422	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 1.1 TO 2.0 CM
11423	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 2.1 TO 3.0 CM
11424	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 3.1 TO 4.0 CM
11426	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER OVER 4.0 CM
11440	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 0.5 CM OR LESS
11441	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 0.6 TO 1.0 CM
11442	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 1.1 TO 2.0 CM
11443	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 2.1 TO 3.0 CM
11444	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 3.1 TO 4.0 CM
11446	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER OVER 4.0 CM
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
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)
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
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
15847	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY), ABDOMEN (EG,
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
17111	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), OF BENIGN LESIONS OTHER THAN SKIN TAGS OR CUTANEOUS
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
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
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
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
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
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
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
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 Codes	**Description**
A9282	WIG ANY TYPE, EACH
C1789	PROSTHESIS, BREAST (IMPLANTABLE)
J0585	INJECTION, ONABOTULINUMTOXINA, 1 UNIT
J0586	INJECTION, ABOBOTULINUMTOXINA, 5 UNITS
J0587	INJECTION, RIMABOTULINUMTOXINB, 100 UNITS
J0588	INJECTION, INCOBOTULINUMTOXINA, 1 UNIT
L8600	IMPLANTABLE BREAST PROSTHESIS, SILICONE OR EQUAL
Q4100	SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED
S0800	LASER IN SITU KERATOMILEUSIS (LASIK)
ICD10 Codes	**Description**
N/A	N/A

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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 HPP to be investigational or experimental, cosmetic or not medically necessary are excluded from coverage for all product lines.

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 HISTORY

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

Summary	Version	Effective Date
2021 Annual policy review. The following codes were deleted and 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
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. ▪ 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 is met. ▪ 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). ▪ No change in coverage criteria. ▪ Language in Guideline section for benign skin lesions (17110, 17111) added to policy.	B	8/1/2016
New Policy. Note: Originally titled “Cosmetic Services” and used a different 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. **CMS.gov National Coverage Determination for Breast Reconstruction following Mastectomy**

3. Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD) **NCD 140.4** - Plastic Surgery to Correct "Moon Face". **CMS.gov National Coverage Determination for Plastic Surgery to Correct Moon Face**

4. 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?NCAId=238&NcaName=Allogeneic+Hematopoietic+Stem+Cell+Transplantation+(HSCT)+for+Myelodysplastic+Syndrome&ExpandComments=y&CommentPeriod=0&NCDId=129**

5. Novitas Solutions, Local Coverage Determination (LCD) L35090 Cosmetic and Reconstructive Surgery. https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35090&ver=69&name=331*1%7c335*1%7c332*1%7c336*1%7c333*1%7c337*1%7c334*1%7c338*1%7c339*1%7c327*1%7c325*1%7c328*1%7c326*1%7c329*1%7c330*1%7c314*1%7c319*1%7c315*1%7c320*1%7c316*1%7c321*1%7c317*1%7c322*1%7c318*1%7c323*1%7c324*1&UpdatePeriod=732&bc=AQAAEAAAgAAA&

6. Novitas Solutions, Local Coverage Determination (LCD) - **L34938** - Removal of Benign or Premalignant Skin Lesions, https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34938&ver=68&name=314*1&UpdatePeriod=765&bc=AAAAEAAAgAAA&

7. Novitas Solutions, Local Coverage Determination (LCD) **L35004** - Surgery: Blepharoplasty: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35004&ver=15&DocID=L35004&bc=gAAAABAAgAAA&

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