

Cosmetic and Reconstructive Surgery

Effective: October 1, 2018

Next Review: May 2019

Last Review: September 2018

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Cosmetic surgery is performed to reshape normal body structures in order to improve appearance.

Reconstructive surgery is primarily performed to improve or correct a functional impairment.

NOTE: This policy is not intended to address treatment of gender dysphoria which is addressed in the Transgender Services medical policy, [Medicine, Policy No. 153](#), which may be applicable.

MEDICAL POLICY CRITERIA

Many member contracts have very specific language regarding covered reconstructive services and excluded cosmetic procedures. Specific member contract language has precedence over medical policy, and requests for coverage of potentially cosmetic services should be reviewed by applicable member contract language.

- I. Medical necessity criteria for specific procedures

[Dermabrasion and Microdermabrasion](#)

[Mastectomy for Gynecomastia](#)

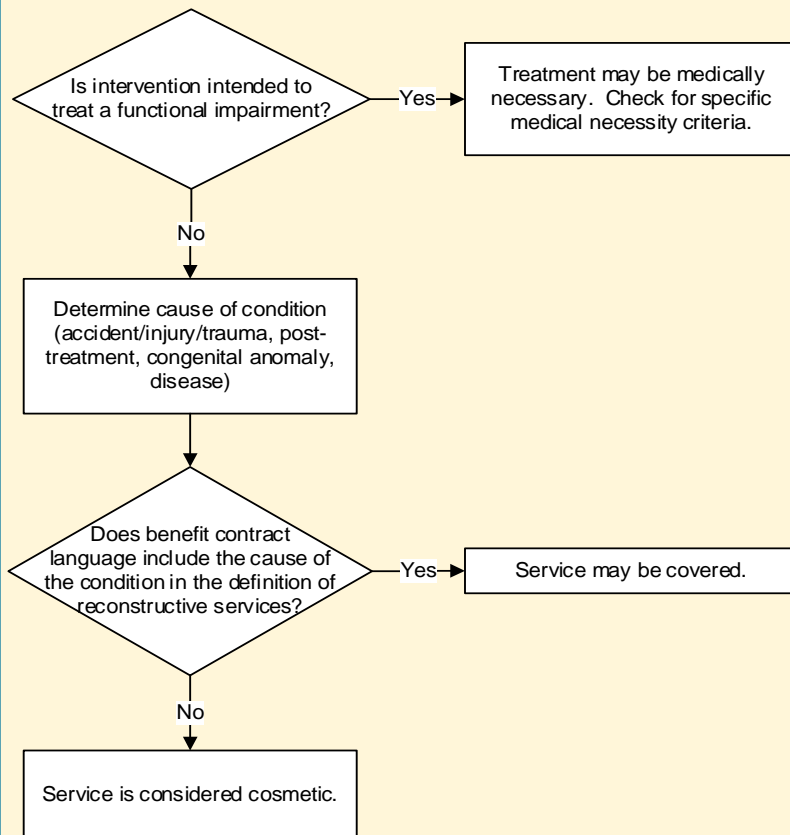
[Reconstructive Breast Surgery/Mastopexy, and Management of Breast Implants](#)

Reduction Mammoplasty

Varicose Vein Treatment

- II. The following criteria may be applied when member contract language is not specific:
- A. If the intervention is intended to treat a functional impairment and if no other contract exclusions apply, it may be considered **medically necessary**.
 - B. If the intervention is not intended to treat a functional impairment, the cause of the condition must be determined, for example, accident/injury/trauma, post-treatment, congenital anomaly, disease. If the cause is included in the definition of reconstructive services in the benefits contract language, then the treatment may be covered.

The following flow chart may be used as a guide to interpreting benefits language.



NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

CROSS REFERENCES

1. [Transgender Services](#), Medicine, Policy No. 153
2. [Endometrial Ablation](#), Surgery, Policy No. 01
3. [Panniculectomy](#), Surgery, Policy No. 12.01
4. [Pectus Excavatam](#), Surgery, Policy No. 12.02
5. [Ventral Hernia Repair](#), Surgery, Policy No. 12.03
6. [Blepharoplasty and Brow Ptosis Repair](#), Surgery, Policy No. 12.05
7. [Rhinoplasty](#), Surgery, Policy No. 12.28
8. [Laser Treatment for Port Wine Stains](#), Surgery, Policy No. 12.34
9. [Chemical Peels](#), Surgery, Policy No. 12.50

10. [Reconstructive Breast Surgery/Management of Breast Implants](#), Surgery, Policy No. 40
11. [Reduction Mammoplasty](#), Surgery, Policy No. 60
12. [Varicose Vein Treatment](#), Surgery, Policy No. 104
13. [Orthognathic Surgery](#), Surgery, Policy No. 137
14. [Autologous Fat Grafting to the Breast and Adipose-derived Stem Cells](#), Surgery, Policy No. 182

DERMABRASION AND MICRODERMABRASION

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DESCRIPTION

Dermabrasion uses a rapidly moving brush to remove skin and activate new skin growth. It is commonly used for the treatment of facial scars and wrinkles.

Microdermabrasion uses small microcrystals to abrade the superficial epidermal layer of the skin; suction is then used to remove any skin debris. Microdermabrasion is often performed by estheticians for facial rejuvenation.

MEDICAL POLICY CRITERIA

- I. Dermabrasion to treat photoaged skin, wrinkles, or acne scarring is considered **cosmetic**.
- II. Microdermabrasion for the treatment of any indication is considered **cosmetic**.

MASTECTOMY FOR GYNECOMASTIA

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DESCRIPTION

Gynecomastia refers to the benign enlargement of the male breast, either due to increased adipose tissue, fibrous tissue, glandular tissue, or a combination of all three. In some instances, adolescent gynecomastia may be reported as tender or painful; however, this pain is normally self-limiting or responds to analgesic therapy. Typically no functional impairment is associated with gynecomastia.

MEDICAL POLICY CRITERIA

Mastectomy as a treatment of gynecomastia is considered **cosmetic**.

REFERENCES

1. BlueCross BlueShield Association Medical Policy Reference Manual "Surgical Treatment of Bilateral Gynecomastia." Policy No. 7.01.13

CODES

Codes	Number	Description
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CPT	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
	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
	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 (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 four lesions or less
	15819	Cervicoplasty
	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
	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
	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
	17380	Electrolysis epilation, each 30 minutes
	17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
	19300	Mastectomy for gynecomastia
	19355	Correction of inverted nipples
	21137	Reduction forehead; contouring only
	21138	Reduction forehead; contouring and application of contouring material or bone graft (includes obtaining autograft)
	21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
	21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
	21245	Reconstruction of mandible, or maxilla, subperiosteal implant; partial
	21246	Reconstruction of mandible, or maxilla, subperiosteal implant; complete
	21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial

	21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete
	21270	Malar augmentation, prosthetic material
	21280	Medial canthopexy
	21282	Lateral canthopexy
	21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach
	21296	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach
	26590	Repair macrodactylia, each digit
	31830	Revision of tracheostomy scar
	41510	Suture of tongue to lip for micrognathia (Douglas type procedure)
	49250	Umbilectomy, omphalectomy, excision of umbilicus
	54360	Plastic operation on penis to correct angulation
	67911	Correction of lid retraction
	67999	Unlisted procedure, eyelids
	69090	Ear piercing
	69300	Otoplasty, protruding ear, with or without size reduction
HCPCS	G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)
	Q2026	Injection, Radiesse, 0.1 ML
	Q2028	Injection, Sculptra, 0.5 mg

Date of Origin: January 1996