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Cosmetic and Reconstructive Procedures
Corporate Medical Policy

File Name: Cosmetic and Reconstructive Procedures
File Code: UM.SURG.02
Last Review: 08/2017
Next Review: 08/2018
Effective Date: 08/01/2018

Description/Summary

The term, "cosmetic and reconstructive procedures" includes procedures ranging from purely cosmetic to purely reconstructive. Benefit application has the potential to be confusing to members because there is an area of overlap where cosmetic procedures may have a reconstructive component and reconstructive procedures may have a cosmetic component. These procedures are categorized and benefits are authorized based upon the fundamental purpose of the procedure. The American Medical Association and the American Society of Plastic Surgeons have agreed upon the following definitions:

- Cosmetic procedures are those that are performed to reshape normal structures of the body in order to improve the patient's appearance and self- esteem.
- Reconstructive procedures are those procedures performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

In order to be considered medically necessary, the goal of reconstructive surgery must be to correct an abnormality in order to restore physiological function to the extent possible. As such, for reconstructive surgery to be considered medically necessary there must be a reasonable expectation that the procedure will improve the functional impairment. A procedure is considered cosmetic if the only desired and/or expected benefits would be emotional or psychological, unless to repair genetic defect.

Requests for procedures listed in this policy should be accompanied by the following documentation:

- The name and date of the proposed surgery
- Preoperative photographs, if appropriate and illustrative
- Date of accident or injury, if applicable
- History of present illness and/or conditions including diagnoses

- Documentation of functional impairment, pain or significant anatomic variance
- How the treatment can be reasonably expected to improve the functional impairment
- If applicable, the description of and CPT® coding for planned staged procedures following acute repair or initial primary repair
- Any additional information listed as indicated for the specific procedures listed below

If the intended service relates to gender reassignment services, please refer to the BCBSVT "Transgender Services" medical policy.

If the intended surgery relates to the breast, please refer to the BCBSVT "Breast Surgery" medical policy.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.
Attachment I – Coding Table

General Guidelines

Correction to Complications of a Cosmetic Procedure: BCBSVT will review procedures intended for correcting complications from a cosmetic procedure, whether the original procedure was medically necessary or a non-covered service. In order for these corrections to be considered medically necessary the subsequent surgery needs to be reconstructive in nature. We consider complications arising from a non-covered service as well as from a medically necessary service when the treatment of the complication itself is **medically necessary.** The purpose of the surgery should generally be performed to improve function, but may also be done to approximate normal appearance.

Congenital Deformities in Children: We consider procedures to correct congenital and developmental deformities in children **medically necessary** when defects are severe or debilitating. These include cleft lip, cleft palate or both, deforming hemangiomas, pectus excavatum and others. See policy for further specifics on each body part. To receive benefits, the patient does not need to have been covered under BCBSVT at time of birth.

EYES

Blepharoplasty (CPT® codes 15820-15823), **Blepharoptosis** (CPT® codes 67900-67911) and **Brow Ptosis Repair** (67900 – 67904, 67906, 67908) - surgery of the eyelid and/or eyebrow and forehead.

Additional Documentation Required:
- Automated visual field study comparing taped to un-taped visual fields, including interpretation and report.
- Preoperative photographs -- one full-frontal view with patient looking directly at

the camera and one view each of the eyes only looking upward and downward. If a combination of blepharoplasty and brow ptosis repair is requested, a photograph with forehead manually lifted to demonstrate that brow ptosis repair alone will not resolve the visual impairment.

* We consider the procedure **medically necessary** for any of the following:
  - 25 % documented reduction of un-taped superior visual field in either eye compared to taped visual field.
  - Frontal photograph noting 50% coverage of pupil by upper eyelid.
  - For brow ptosis repair, frontal photograph showing eyebrow below the upper orbital rim.

Note: Approval will be for a bilateral upper lids if both eyes meet criteria.

* We consider blepharoplasty **not medically necessary** when the above criteria is not met
* We consider the following procedure **cosmetic and therefore not covered as a benefit exclusion:**
  - Blepharoplasty (CPT® codes 15820 & 15821) for lower lids due to blepharochalasis.
  - Blepharoplasty and blepharoptosis when performed only to improve the patient's appearance and self-esteem.

Lateral Canthopexy (CPT® code 21282)

* We consider the procedure **medically necessary** for the following:
  - As a part of facial reconstruction after accidental injury, trauma, disease (e.g. infection) or congenital anomaly.
* We consider the procedure **cosmetic and therefore not covered as a benefit exclusion** when completed for the following reasons:
  - To fix eyelids that droop or sag due to sun damage.
  - To fix eyelids that droop or sag due to aging.

HEAD

Malar augmentation, with prosthetic material (CPT® code 21270)

Additional Documentation Required:
  - History of present illness and history and physical report demonstrating physical impairment caused by disease, trauma, and/or congenital defect.

* We consider the procedure **medically necessary** for the following:
  - Part of facial reconstruction after accidental injury, trauma or disease (e.g. infection, tumor of the face).
  - To correct a significant congenital anomaly.
* We consider the procedure **cosmetic and therefore not covered as a benefit exclusion** for all other indications.

Orthognathic Procedures (CPT® codes 21127, 21137-21139, 21141-21160, 21206-21209)

** For procedures related to TMJ, please refer to the BCBSVT medical policy on TMJ. For procedures related to obstructive sleep apnea please refer to the BCBSVT medical*

policy on Sleep Disorders Diagnosis and Treatment.

Additional Documentation Required:

- History of present illness and history and physical report demonstrating physical impairment caused by disease, trauma, and/or congenital defect.
- Pictures and x-rays illustrating the deformity, both frontal and profile
- Additionally, for those under 18 years of age, one of the following must be submitted as evidence of puberty completion.*

    * Evidence of puberty completion:
        - *Documented tanner stage IV or V for members aged 15-18,* ***and***
        - *Stable height measurements for 6 months,* ***or***
        - *Puberty completion as shown on wrist radiograph*.

∗ We consider the orthognathic procedures **medically necessary** for the following:

- Prognathism or micrognathism with documented severe handicapping malocclusion with any of the following:
    - Deep impinging overbite with severe soft tissue damage
    - Impacted permanent anterior teeth
    - Class III malocclusion
    - Overjet of at least 4.00mm
    - Overbite of at least 2.00 mm
    - Difficulty chewing or biting food
    - Difficulty swallowing
    - Open bite (space between the upper and lower teeth when the mouth is closed)
    - Inability to make lips meet without straining
    - Severe mandibular atrophy
- Diagnosis of Crouzon's syndrome
- Diagnosis of Treacher Collins' dysostosis
- Diagnosis of Romberg's Disease with severe facial deformity
- Other significant cranio-facial abnormalities related to structure and growth or trauma that include:
    - Cleft palate deformities
    - Other birth defects
    - Severe traumatic deviations causing severe handicapping malocclusion referenced above.
- LeFort osteotomy for any of the following may be used alone or in combination with other orthognathic procedures:
    - Correction of midface deformities due to trauma or congenital anomalies
    - Treatment of Class II and Class III malocclusions

∗ We consider a the orthognathic procedure **cosmetic and therefore not covered as a benefit exclusion** for the following:

- In the absence of severe handicapping malocclusion,
- Trauma,
- Congenital anomaly,
- Intended to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

∗ We consider mentoplasty/genioplasty (CPT® codes 21120- 21125) for familial chin deformities or "weak chin" **cosmetic and therefore not covered as a benefit exclusion**.

* Orthodontics, including orthodontics performed as adjunct to orthognathic surgery **are not covered as they are a benefit exclusion** even if the orthognathic surgery itself is considered medically necessary.

Otoplasty – Reconstruction of external auditory canal (69300, 69310, 69320 & 69399)
Documentation Required:

- History and physical examination
- Photographs

* We consider the procedure **medically necessary** for the following:
  - Surgically correctable congenital malformation, trauma, surgery, infection, or other process that is causing hearing loss. [Audiogram must demonstrate a loss of at least 15 decibels in the affected ear(s).
  - To restore a significantly abnormal external ear or auditory canal related to trauma, tumor, surgery, infection, or congenital malformation (e.g. atresia).
  - Congenital absence (anotia) or underdevelopment of the external ear (microtia).
* We consider the procedure **cosmetic and therefore not covered as a benefit exclusion** for all other indications, including the following (not an all-inclusive list):
  - Keloids and/or clefts.
  - To reshape the ear due to consequences of ear piercing or ear gauging in the absence of significant physical dysfunction.
  - "Lop ears" or protruding ears.

Rhinoplasty/Septorhinoplasty (CPT® codes 30120, 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30520, 30620, 30630) - surgery of the nose.
Additional Documentation Required

- History of present illness and history and physical report.
- Preoperative photographs -- one frontal view, one profile one view with head held back.
- Date of previous surgery, if applicable.
- Date of accident or injury, if applicable.
- Name & location of the treating physician at the time of accident.
- Emergency room or office records, including x-ray or x-ray reports, if available and applicable.

* We consider the procedure **medically necessary** for the following:
  - Airway obstruction from deformities due to disease, congenital abnormality, or trauma that will not or would not be expected to respond to medication therapy and will not respond to septoplasty alone, or
  - Immediate or planned-staged reconstruction following trauma, tumor, surgery or infection of the nose.
* We consider the procedure **cosmetic and therefore not covered as a benefit exclusion** for the following:
  - To reshape a functional nose in the absence of airway obstruction from deformities due to disease, congenital abnormality, previous therapy or trauma that will not or would not be expected to respond to medication therapy and will not respond to septoplasty alone and performed only to improve the patient's appearance and self-esteem.
  - To reshape the nose related to consequences of nose piercing or nose gauging.

- To reshape the nose due to rhinopyma.

SKIN

Bio-engineered Skin and Soft Tissue Substitutes (e.g. Hyalomatrix, AlloDerm, Apligraf, Epicel, etc.)
See separate BCBSVT medical policy Bio-Engineered Skin and Soft Tissue Substitutes.

Chemical Peels (CPT® codes 15788, 15789, 15792, 15793, 17360) procedures utilizing various chemical or freezing agents (e.g. carbon dioxide slush or liquid nitrogen).
See separate BCBSVT medical policy Chemical Peels.

Cryotherapy for the Treatment of Acne Vulgaris (CPT® codes 17340):
Additional Documentation Required
- History of present illness and history and physical report.
- Photograph demonstrating affected area.

* We consider the procedure **medically necessary** when both of the following are met:
  - Active acne.
  - Documented evidence of failure of a trial of topical retinoid treatment, topical antibiotic therapy, and oral antibiotic therapy.
* We consider the procedure **not medically necessary** when there has not been a trial of topical retinoid treatment, topical antibiotic therapy, and oral antibiotic therapy.
* We consider the procedure **cosmetic and therefore not covered as a benefit exclusion** for the following:
  - In the absence of active acne.
  - To remove acne scaring to improve the patient's appearance and self-esteem.

Dermabrasion (CPT® codes 15780 –15783) – Surgical procedure for removal of scars on the skin by using sandpaper or mechanical methods on the frozen epidermis.
Additional Documentation Required:
- History of present illness and history and physical report.
- Date of accident or injury, if applicable.
- Photograph demonstrating affected area.

* We consider the procedure **medically necessary** for any of the following:
  - Restoration following previous injury or surgery with severe disfigurement or functional and physiological impairment.
  - Documented evidence of 10 or more superficial basal cell carcinomas, actinic keratoses, or other pre-malignant skin lesions that have failed topical retinoid treatment, topical chemotherapeutic agents, and cryotherapy.
* We consider the procedure **not medically necessary** for the treatment of all other conditions.
* We consider the procedure **cosmetic and not a covered benefit** to treat the following:
  - Scarring from acne vulgaris
  - Skin wrinkling
  - Rhinophyma

- Tattoo Removal

Laser Treatment of Port Wine Stains/Deforming Hemangiomas (CPT® codes 17106 to 17108)
See separate BCBSVT medical policy "Laser Treatment of Port Wine Stains."

Light Therapy for Psoriasis (CPT® codes 96900, 96912, 96920, 96921, 96922; HCPCS code J8999)
See separate BCBSVT medical policy "Light Therapy for Psoriasis."

Light Therapy for Vitiligo (CPT® 96912 and 96999)
See separate the BCBSVT medical policy "Light Therapy for Vitiligo."

Photodynamic Therapy: Dermatological Applications (CPT® code 96567; HCPCS codes J7308) - for the treatments of actinic keratosis, carcinomas of the skin and acne vulgaris
See separate the BCBSVT medical policy "Dermatologic Applications of Photodynamic Therapy."

Removal of Benign Skin Lesions (e.g. skin tags and warts) (CPT® codes 11200, 11201, 11300 -11303, 11305 -11313, 11400 -11404, 11406, 11420 -11424, 11426, 11440 -11444, 11446, 17000, 17003, 17004, 17110, 17111)

* We consider the procedure **medically necessary** for the following:
  - When there is documentation of functional impairment or pain and the expectation that treatment can be reasonably expected to improve the impairment

* We consider the procedure **cosmetic and therefore not covered as a benefit exclusion** for the following:
  - In the absence of any functional impairment, pain, or expectation that treatment can be reasonably expected to improve the impairment

Rosacea: Non-pharmacological Treatments (CPT® codes 15780 - 15783, 15788 - 15793, 17106 - 17108, 30117, 30118)
See separate BCBSVT medical policy "Non-pharmacologic Treatment of Rosacea."

Scar and Keloid Revision (CPT® codes 17110, 17111)
Additional Documentation Required:
- History of present illness and history and physical report
- Preoperative photograph
- Date of accident or injury, if applicable
- Description of and CPT® coding for planned staged procedure following acute repair, within two years of previous stage or initial primary repair.

* We consider the procedure **medically necessary** for the following:
  - To treat functional impairment or pain with the expectation that treatment can be reasonably expected to improve the impairment.

* We consider the procedure **cosmetic and therefore not covered as a benefit exclusion** for the following:
  - In the absence of any functional impairment, pain, or expectation that treatment

can be reasonably expected to improve the impairment.
- To correct any consequences related to piercing or gauging.

Tattooing of the Skin (CPT® codes 11920, 11921 & 11922)
Additional Documentation Required
- Clinical statement indicating tattooing is in conjunction with medically necessary procedures (e.g. nipple reconstruction post mastectomy)

* We consider the procedure **medically necessary** with approval of primary procedure (e.g. breast reconstruction following mastectomy)
* We consider the following **cosmetic and therefore not covered as a benefit exclusion**:
  - Placement, removal or coverage of decorative tattoos.
  - Tattooing of the skin for color differential as a result of vitiligo.

*No PA is required for tattooing of the skin for breast reconstruction when submitted with a diagnosis of breast cancer. Refer to separate BCBSVT medical policy for Breast Surgery.

Ultraviolet Light Systems for Home Use (HCPCS codes E0691– E0694)
* We consider light box therapy for ultraviolet light A (UVA) and ultraviolet light B (UVB) **medically necessary** when all of the following are met:
  - When there is psoriasis defined as more than 5% of the body surface area affected.
  - Condition is considered a refractory disease, defined as failure of adequate trials of topical regimens (unmanageable or resistant to treatment).
  - Member requires ultraviolet light treatments at least 3 times a week and has demonstrated some improvement with initial treatment in either the provider's office or facility, for the previous two months
* We consider the use of home-based psoralens with Ultraviolet light A (PUVA) **not medically necessary**.
* We consider light box therapy for the treatment of vitiligo **cosmetic and not a covered benefit**

TORSO

Panniculectomy, Abdominoplasty (CPT® code 15830 & 15847) - removal of fatty tissue
Additional Documentation Required:
- History of present illness and physical examination including weight values for the last six months
- Pre-operative photographs -- one full-body anterior photograph of the patient standing straight and one photograph of the abdominal fold, raised to document any reported skin changes, e.g., dermatitis ulceration, and one lateral photograph

* We consider the procedure **medically necessary** when:
  - Panniculus hangs below the level of pubis, **and**
  - Documented weight loss is greater than 100 lbs or reduction of BMI to16.2 (equivalent to 100 lbs in an individual of 5'6" height) or greater, or has reached a body mass index (BMI) of <30, **and**

- Weight is stable for a period in excess of six months and, if weight loss is due to bariatric surgery, member is at least 18 months post- operative, **and**
- Evidence of either a significant functional impairment such as difficulty with ambulation, activities of daily living, or initiation of a fitness program to sustain weight loss or of chronic skin rashes, local infection, cellulitis, or ulcers that does not respond to conventional treatment for a period of 3 months

* We consider abdominoplasty and panniculectomy **cosmetic and therefore not covered as a benefit exclusion** when performed in the absence of any functional impairment and intended just to improve the patient's appearance and self-esteem.

Pectus Excavatum or Pectus Carinatum Repair (CPT® Code 21740, 21742, 21743) is the reconstruction / repair of chest wall deformity in children up to 18 years old.
Additional Documentation Required:

- History and physical examination
- Frontal and side photographs of chest
- Statement from physician delineating cardiovascular and pulmonary risk

* We consider the procedure **medically necessary** for any of the following:
  - A Haller index of 3.2 or greater (which is suggested to be a future predictor of cardiovascular compromise) for pectus excavatum.
  - When based upon the requesting physician's clinical judgement the magnitude of the deformity places the patient at risk of impending cardiovascular or respiratory compromise.
  - To correct chest deformities resulting from trauma, infection or disease
* We consider the procedure **cosmetic and not a covered benefit** when performed in the absence of any functional impairment and intended just to improve the patient's appearance and self-esteem.

OTHER

Collagen Injections (CPT® codes 11950 – 11954 & 11960) – subcutaneous injection of filling material to restore physiologic function
Additional Documentation Required

- History of present illness and history and physical report demonstrating physical impairment caused by disease, trauma, and/or congenital defect

* We consider the procedure **medically necessary** for the following:
  - Documented evidence of significant functional impairment and the expected functional improvement following correction of a physical impairment caused by disease, trauma, and/or congenital defect
* We consider the procedure **cosmetic and therefore not a covered benefit** when performed in the absence of any functional impairment and intended just to improve the patient's appearance and self-esteem.

Lipectomy- the excision of a mass of subcutaneous adipose tissue from the body.

* We consider the following procedures **cosmetic and therefore not covered as a benefit exclusion** for the following:
  - Low-level laser (cold laser) therapy (e.g. Zerona).
  - Excision, excessive skin and subcutaneous tissue for any part of the body (CPT®

codes 15830-15839 & 15847).
- Suction assisted lipectomy (liposuction) (CPT® codes 15876 – 15879) as a primary procedure *Note: suction assisted lipectomy may be eligible for benefits under individual consideration as an adjunct to an authorized reconstructive procedure.

Testicular Prosthesis Insertion (CPT® 54660) – insertion of a prosthesis to replace a testicle due to congenital absence or surgical removal.
Documentation Required:
- Clinical statement by physician that testicle was either congenitally absent or was surgically removed (due to disease or trauma)
- Date and nature of proposed surgery

∗ We consider the procedure **medically necessary** for the following:
- Insertion of a testicular prosthesis may be considered medically necessary due to congenital or acquired absence of a testicle

Procedures related to Genitalia
If the intended service relates to gender reassignment services, please refer to the BCBSVT Transgender Services medical policy.

- Vaginoplasty (57335)- reconstruction or rejuvenation of the vagina
- Clitoroplasty (56805) – reconstruction or reduction of the clitoris
- Labiaplasty- reconstruction or reduction of the labia
- Vulvectomy (56625) – removal of part or all of the vulva
- Vulvoplasty – reconstruction of the vulva
- Phalloplasty – penis lengthening surgery
- Scrotoplasty (55175, 55180)- surgery to the scrotal sack following:
  - A congenital anomaly is present
  - With a medical diagnosis of cancer affecting the area
  - The area is affected by severe infection and/or trauma or causing severe functional impairment- The request must include documented evidence of significant functional impairment and the expected functional improvement following correction of physical impairment

∗ We consider the procedure **cosmetic and therefore a non-covered as a benefit exclusion** when the above medically necessary criteria is not met and the procedure is performed in order to improve the patient's appearance and self-esteem. This includes penis lengthening or labia clipping.

COSMETIC EXCLUSIONS

Cosmetic procedures are a specific exclusion under the subscriber's contract.
∗ The following is a list that includes, but is not limited to, procedures that are considered **cosmetic and therefore non-covered services**:
- Rhytidectomy for the signs of aging
- Hair transplants
- Diastasis Recti correction – surgery to correct a separation of the lower abdominal muscles in the midline
- Ear or Body Piercing – ear and body piercing are considered cosmetic and not

medically necessary for all reasons

- Hair Procedures – Hair transplant for alopecia (including male pattern alopecia) or hair removal (temporary or permanent) for all indications.
- Laser treatment of telangiectasia.

Reference Resources

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Related Policies

BCBSVT Medical Policy on Transgender Services
BCBSVT Medical Policy on Breast Surgery
BCBSVT Medical Policy on Dermatologic Applications of Photodynamic Therapy
BCBSVT Medical Policy on Temporomandibular Joint (TMJ) Disease
BCBSVT Medical Policy on Sleep Disorders Diagnosis and Treatment
BCBSVT Medical Policy on Bioengineered Skin and Soft Tissue Substitutes
BCBSVT Medical Policy on Chemical Peels
BCBSVT Medical Policy on Laser Treatment of Port Wine Stains
BCBSVT Medical Policy on Light Therapy for Psoriasis
BCBSVT Medical Policy on Light Therapy for Vitiligo
BCBSVT Medical Policy on Non-Pharmacologic Treatment of Rosacea

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to

recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required. NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

06/2016	Updated sections. New criteria added. CPT®s embedded within each section. References updated. Breast surgery removed and a new policy for breast surgery has been created.
08/2017	Added coding table to align with codes contained within the medical policy. Added related policies Policy statement remained unchanged.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors **Date Approved**

Gabrielle Bercy-Roberson, MD, MPH, MBA
Senior Medical Director
Chair, Health Policy Committee

Joshua Plavin, MD, MPH, MBA
Chief Medical Officer

Attachment I
Coding Table

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	
CPT®	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)	
CPT®	11300	Shaving of epidermal or dermal lesions, single lesion, trunk, arms or legs; lesion diameter 0.5cm or less	
CPT®	11301	Shaving of epidermal or dermal lesions, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	
CPT®	11302	Shaving of epidermal or dermal lesions, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	
CPT®	11303	Shaving of epidermal or dermal lesions, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm	
CPT®	11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck,	

		hands, feet, genitalia; lesion diameter 0.5 cm or less	
CPT®	11306	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	
CPT®	11307	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	
CPT®	11308	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm	
CPT®	11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	
CPT®	11311	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	
CPT®	11312	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	
CPT®	11313	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm	
CPT®	11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	
CPT®	11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm	
CPT®	11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm	

CPT®	11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm	
CPT®	11404	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm	
CPT®	11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm	
CPT®	11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	
CPT®	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	
CPT®	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	
CPT®	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	
CPT®	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	
CPT®	11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm	
CPT®	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	
CPT®	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	
CPT®	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	
CPT®	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	
CPT®	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	
CPT®	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	
CPT®	11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	Prior Approval Required
CPT®	11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	Prior Approval Required
CPT®	11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each	Prior Approval Required

		additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure	
CPT®	11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	Prior Approval Required
CPT®	11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	Prior Approval Required
CPT®	11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	Prior Approval Required
CPT®	11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	Prior Approval Required
CPT®	11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	Prior Approval Required
CPT®	15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	Prior Approval Required
CPT®	15781	Dermabrasion; segmental, face	Prior Approval Required
CPT®	15782	Dermabrasion; regional, other than face	Prior Approval Required
CPT®	15783	Dermabrasion; superficial, any site (eg, tattoo removal)	Prior Approval Required
CPT®	15788	Chemical peel, facial; epidermal	Prior Approval Required
CPT®	15789	Chemical peel, facial; dermal	Prior Approval Required
CPT®	15792	Chemical peel, nonfacial; epidermal	Prior Approval Required
CPT®	15793	Chemical peel, nonfacial; dermal	Prior Approval Required
CPT®	15820	Blepharoplasty, lower eyelid;	Prior Approval Required if not a benefit exclusion in members plan document.
CPT®	15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	Prior Approval Required if not a benefit exclusion in members plan document.
CPT®	15822	Blepharoplasty, upper eyelid;	Prior Approval Required if not a benefit exclusion in members plan document.
CPT®	15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	

			Prior Approval Required if not a benefit exclusion in members plan document.
CPT®	15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	Prior Approval Required if not a benefit exclusion in members plan document.
CPT®	15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	Prior Approval Required if not a benefit exclusion in members plan document.
CPT®	15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	Prior Approval Required if not a benefit exclusion in members plan document.
CPT®	15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	Prior Approval Required
CPT®	15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	Prior Approval Required
CPT®	15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	Prior Approval Required
CPT®	15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	Prior Approval Required
CPT®	15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	Prior Approval Required
CPT®	15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	Prior Approval Required
CPT®	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)	Prior Approval Required
CPT®	17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratosis); first lesion	
CPT®	17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery,	

		chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratosis); second through 14 lesions, each (List separately in addition to code for first lesion)	
CPT®	17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratosis), 15 or more lesions	
CPT®	17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Prior Approval Required
CPT®	17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Prior Approval Required
CPT®	17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Prior Approval Required
CPT®	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	
CPT®	17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions	
CPT®	17340	Cryotherapy (CO_2 slush, liquid N2) for acne	Prior Approval Required
CPT®	17360	Chemical exfoliation for acne (eg, acne paste, acid)	Prior Approval Required
CPT®	21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	Prior Approval Required
CPT®	21121	Genioplasty; sliding osteotomy, single piece	Prior Approval Required
CPT®	21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision ot bone wedge reversal for asymmetrical chin)	Prior Approval Required

CPT®	21123	Genioplasty; sliding augmentation with interpositional bone grafts (including obtaining autografts)	Prior Approval Required
CPT®	21125	Augmentation, mandibular body or angle; prosthetic material	Prior Approval Required
CPT®	21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	Prior Approval Required
CPT®	21137	Reduction forehead; contouring only	Prior Approval Required
CPT®	21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)	Prior Approval Required
CPT®	21139	Reduction forehead; contouring and setback of anterior frontal sinus wall	Prior Approval Required
CPT®	21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft	Prior Approval Required
CPT®	21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft	Prior Approval Required
CPT®	21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	Prior Approval Required
CPT®	21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	Prior Approval Required
CPT®	21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts (eg, ungrafted unilateral alveolar cleft)	Prior Approval Required
CPT®	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)	Prior Approval Required

CPT®	21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	Prior Approval Required
CPT®	21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	Prior Approval Required
CPT®	21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	Prior Approval Required
CPT®	21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I	Prior Approval Required
CPT®	21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I	Prior Approval Required
CPT®	21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	Prior Approval Required
CPT®	21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	Prior Approval Required
CPT®	21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	Prior Approval Required
CPT®	21209	Osteoplasty, facial bones; reduction	Prior Approval Required
CPT®	21270	Malar augmentation, prosthetic material	Prior Approval Required
CPT®	21282	Lateral canthopexy	Prior Approval Required
CPT®	21740	Reconstructive repair of pectus excavatum or carinatum; open	Prior Approval Required
CPT®	21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy	Prior Approval Required
CPT®	21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy	Prior Approval Required

CPT®	30117	Excision or destruction (eg, laser), intranasal lesion; internal approach	
CPT®	30118	Excision or destruction (eg, laser), intranasal lesion; external approach (lateral rhinotomy)	
CPT®	30120	Excision or surgical planning of skin of nose for rhinophyma	Prior Approval Required
CPT®	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	Prior Approval Required
CPT®	30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	Prior Approval Required
CPT®	30420	Rhinoplasty, primary; including major septal repair	Prior Approval Required
CPT®	30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	Prior Approval Required
CPT®	30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	Prior Approval Required
CPT®	30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	Prior Approval Required
CPT®	30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	Prior Approval Required
CPT®	30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies	Prior Approval Required
CPT®	30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	
CPT®	30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)	
CPT®	30630	Repair nasal septal perforations	Prior Approval Required
CPT®	54660	Insertion of testicular prosthesis (separate procedure)	Prior Approval Required
CPT®	55175	Scrotoplasty; simple	Prior Approval Required

CPT®	55180	Scrotoplasty; complicated	Prior Approval Required
CPT®	56625	Vulvectomy simple; complete	Prior Approval Required
CPT®	56805	Clitoroplasty for intersex state	Prior Approval Required
CPT®	57335	Vaginoplasty for intersex state	Prior Approval Required
CPT®	67900	Repair for brow ptosis (supraciliary, mid-forehead or coronal approach)	Prior Approval Required
CPT®	67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	Prior Approval Required
CPT®	67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	Prior Approval Required
CPT®	67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	Prior Approval Required
CPT®	67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	Prior Approval Required
CPT®	67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	Prior Approval Required
CPT®	67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)	Prior Approval Required
CPT®	67909	Reduction of overcorrection of ptosis	Prior Approval Required
CPT®	67911	Correction of lid retraction	Prior Approval Required
CPT®	69300	Otoplasty, protruding ear, with or without size reduction	Prior Approval Required
CPT®	69310	Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection) (separate procedure)	Prior Approval Required
CPT®	69320	Reconstruction external auditory canal for congenital atresia, single stage	Prior Approval Required
CPT®	69399	Unlisted procedure, external ear	Prior Approval Required
CPT®	96567	Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (Eg, lip) by activation of	Prior Approval Required

		photosensitive drug(s), each phototherapy exposure session	
CPT®	96900	Actinotherapy (ultraviolet light)	Prior Approval Required
CPT®	96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	Prior Approval Required
CPT®	96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm)	Prior Approval Required
CPT®	96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm)	Prior Approval Required
CPT®	96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm	Prior Approval Required
CPT®	96999	Unlisted special dermatological service or procedure	Prior Approval Required
HCPCS	E0691	Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less	Prior Approval not required if purchase price is under $500.00
HCPCS	E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel	Prior Approval not required if purchase price is under $500.00
HCPCS	E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 foot panel	Prior Approval not required if purchase price is under $500.00
HCPCS	E0694	Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection	Prior Approval not required if purchase price is under $500.00
HCPCS	J7308	Aminolevulinic acid HCL for topical administration, 20%, single unit dosage form (354 mg)	
HCPCS	J8999	Prescription drug, oral, chemotherapeutic, NOS	
The following codes will be denied as a benefit exclusion			
CPT®	15876	Suction assisted lipectomy; head and neck	
CPT®	15877	Suction assisted lipectomy; trunk	
CPT®	15878	Suction assisted lipectomy; upper extremity	
CPT®	15879	Suction assisted lipectomy; lower extremity	