Cosmetic and Reconstructive Procedures
Corporate Medical Policy

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Description
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 “Gender Reassignment Services for Gender Dysphoria” medical policy.

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

Policy and Guidelines

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:
  o Automated visual field study comparing taped to un-taped visual fields, including interpretation and report.
  o 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:
  o History and physical examination
  o Photographs

• We consider the procedure **medically necessary** for the following:
  o 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).]
  o To restore a significantly abnormal external ear or auditory canal related to trauma, tumor, surgery, infection, or congenital malformation (e.g. atresia).
  o Congenital absence (anotia) or underdevelopment of the external ear (microtia).

• We consider the procedure **cosmetic and not covered as a benefit exclusion** for all other indications, including the following (not an all-inclusive list):
  o Keloids and/or clefts.
  o To reshape the ear due to consequences of ear piercing or ear gauging in the absence of significant physical dysfunction.
  o “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
  o History of present illness and history and physical report.
  o Preoperative photographs -- one frontal view, one profile one view with head held back.
  o Date of previous surgery, if applicable.
  o Date of accident or injury, if applicable.
  o Name & location of the treating physician at the time of accident.
  o 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:
  o 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
  o 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:
  o 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.
  o To reshape the nose related to consequences of nose piercing or nose gauging.
  o 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
  o History of present illness and history and physical report.
  o Photograph demonstrating affected area.
• We consider the procedure medically necessary when both of the following are met:
  o Active acne.
  o 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:
  o In the absence of active acne.
  o 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
  o History of present illness and history and physical report.
  o Date of accident or injury, if applicable.
  o 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-pharmalogical 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 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 (CPT 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 in BMI of 16.2 (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 (in the absence of Gender Identity Disorder*)
  - 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
• We consider the above procedures medically necessary when for any of the following:
  o A congenital anomaly is present
  o With a medical diagnosis of cancer affecting the area
  o 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.

* If the intended service relates to gender dysphoria, please refer to the BCBSVT “Gender Reassignment Services for Gender Dysphoria” medical policy.

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:

1. Rhytidectomy for the signs of aging
2. Hair transplants
3. Diastasis Recti correction - surgery to correct a separation of the lower abdominal muscles in the midline
4. Ear or Body Piercing - ear and body piercing are considered cosmetic and not medically necessary for all reasons
5. Hair Procedures - Hair transplant for alopecia (including male pattern alopecia) or hair removal (temporary or permanent) for all indications.

Reference Resources


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 for many services outlined in this policy. 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) only
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. CPTs embedded within each
section. References updated. Breast surgery removed and a new policy
for breast surgery has been created. |
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