Clinical Policy: Cosmetic and Reconstructive Procedures

Reference Number: CP.MP.31
Last Review Date: 09/20 Revision Log

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

Description
This policy will provide general guidelines as to when cosmetic and reconstructive surgery is or is not medically necessary. Not all cosmetic procedures are listed in this policy. The Medical Director has the final decision to deny coverage for services deemed cosmetic in nature and not medically necessary.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that *reconstructive procedures* are considered **medically necessary** when meeting all of the following:

A. Intent of the procedure meets one of the following:
   1. The procedure is performed to improve the function of an abnormal body part caused by illness, trauma, or a congenital defect after failure of conservative therapy;
   2. Skin tag removal when located in an area of friction with documentation of repeated irritation and bleeding (refer to Benefit Plan Contract for any coverage restrictions);
   3. Scar/keloid revision/removal when accompanied by pain unresponsive to standard therapy and is recurrently infected, unstable, friable; or with functional impairment;
   4. Certain reconstructive procedures may be covered if improving appearance is the only benefit, e.g. post-mastectomy breast reconstruction. These procedures may include, but are not limited to:
      a. Post-mastectomy* or lumpectomy resulting in asymmetry: breast reconstruction, including nipple reconstruction, tattooing and surgery on contralateral breast to restore symmetry;
      b. Use of FDA-approved facial dermal injections (Sculptra™, Radiesse®) or autologous fat transfers for HIV-associated wasting** when meeting both of the following:
         i. Diagnosis of HIV (human immunodeficiency virus) or AIDS (acquired immunodeficiency syndrome);
         ii. Diagnosis of facial lipodystrophy syndrome (FLS);

Note: Please refer to CP.MP.95 Gender Affirming procedures for procedures related to treatment of gender dysphoria.

B. Medical records with photographs are provided, as applicable.

Refer to the most current version of the Health Plan-adopted nationally recognized decision support tools for other procedures that may be considered cosmetic in certain cases.

*Note: This includes reconstruction after prophylactic mastectomy with BRCA mutation if the mastectomy is a covered benefit in the State.

**Note: For Sterostim (somatropin) for HIV-associated wasting, see *CP.PHAR.55 Somatropin* or *CP.PCH.25 Somatropin*. For Egrifta (tesamorelin) for LPS, see *CP.PHAR.109 Tesamorelin.*

II. It is the policy of Health Plans affiliated with Centene Corporation that *cosmetic surgery* is **not medically necessary** and generally not a covered benefit when performed to improve a patient's normal appearance and self-esteem. These procedures include, but are not limited to:

A. Excision of excessive skin
B. Body contouring
C. Body lift
D. Breast augmentation
E. Liposuction, excluding lipoma as directed by InterQual® criteria
F. Surgery to correct unsatisfactory results from previous cosmetic and/or non-covered service
G. Revision, removal, or replacement of breast implants previously placed for cosmetic reasons
H. Removal of excess skin or body contouring procedures following weight loss or bariatric surgery when removal is solely cosmetic
I. Facial augmentation
J. Abdominoplasty
K. Dermabrasion
L. Skin rejuvenation and resurfacing
M. Electrolysis, laser hair removal
N. Hair transplantation, when not performed to correct permanent hair loss caused by disease or injury
O. Tattooing (except when covered for breast reconstruction post-mastectomy)
P. Injectable filler
Q. Circumcision revisions done only to improve appearance
R. Mastopexy (except for breast reconstruction post-mastectomy or lumpectomy resulting in significant asymmetry).
S. Correction of inverted nipples
T. Repair of diastasis recti.

Background

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

Cosmetic surgery is performed to reshape normal structures of the body in order to improve the appearance and self-esteem of a patient. It is generally not considered medically necessary.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT Codes Codes	Description
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
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)
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm
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

CPT Codes Codes	Description
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)
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)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
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

CPT Codes Codes	Description
15220	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less
15221	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm, 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
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, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
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
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
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
19303	Mastectomy, simple, complete
19316	Mastopexy
19318	Reduction mammaplasty
19324	Mammaplasty, augmentation without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19328	Removal of intact mammary implant
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

CPT Codes Codes	Description
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
19366	Breast reconstruction with other technique
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

HCPCS Codes	Description
G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) as a result of highly active antiretroviral therapy)
Q2026	Injection, Radiesse, 0.1 ml
Q2028	Injection, Sculptra, 0.5 mg

Reviews, Revisions, and Approvals	Date	Approval Date
Original creation	03/09	03/09
Template updated References reviewed Criteria for panniculectomy removed and placed into CP.MP.109	04/16	04/16
References reviewed and updated	4/17	04/17
References reviewed and updated	03/18	03/18
Minor reorganization to section I. without content change.	04/18	
Reorganized section 1 for clarity. Removed requirement that scar and keloid revisions must be in members under 18 years. Moved statement regarding documentation of medical records, photos. Removed specific mention of documentation of conservative therapies in the medical records criteria. Reorganized description and background sections.	03/19	03/19
Removed “significant” in I.A.4.a. In II. N. changed “hair replacement” to “hair transplantation.” Added additional not medically necessary indications i.e., (mastopexy except for breast reconstruction post-	02/20	03/20

Reviews, Revisions, and Approvals	Date	Approval Date
mastectomy or lumpectomy resulting in significant asymmetry, correction of inverted nipples, and repair of diastasis recti. Specialist reviewed. References reviewed and updated.		
Added criteria for dermal injections and autologous fat injections for HIV-associated FLS. Changed policy title and medical necessity statements to state "cosmetic procedures" or "reconstructive procedures" instead of "cosmetic surgery" or "reconstructive surgery." Added CPT and HCPCS codes for specified medically necessary indications. Added note to refer to CP.MP.95 Gender Affirming procedures for procedures related to treatment of gender dysphoria	04/20	05/20
Clarified in II.N. that hair transplant is not medically necessary, when not performed to correct permanent hair loss caused by disease or injury. Added the following applicable CPT codes: 15220,15221, 15775, 15776. Supporting references added.	09/20	09/20

References

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical

policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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

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

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

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

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

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