EVH Medical Payment Guideline 2515.CC for Cosmetic and Reconstructive Procedures

Guideline Number: EVH_MP_2515.CC	Applicable Codes	
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STATEMENT

General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines, and state/national recommendations.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

Special Note

For services related to **Gender Affirmation**, please refer to the CountyCare Medical Prior Authorization Policy EVH_CG_2719.CC for Surgical Treatment of Gender Dysphoria.

INDICATIONS

CountyCare considers **Reconstructive Services** medically necessary for either of the following:

- When the procedure is intended to primarily improve, restore, or maintain bodily function as a result of trauma, injury, infection, tumor, or disease.

  OR

- The procedure is intended to correct a congenital defect or developmental abnormality, that has resulted in a significant functional impairment.

A functional, physical or physiological impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas:

- physical and motor tasks
- independent movement
- performing basic life functions

Facial Procedures

Eyelids

Blepharoplasty

Upper blepharoplasty: A surgical procedure to remove redundant (excess) tissue from the upper eyelid(s) may be medically necessary for the following:

- To correct prosthesis difficulties associated with an ophthalmic socket.
- To repair conditions causing corneal or conjunctival irritation, such as entropion, ectropion, pseudo trichiasis, or chronic dermatitis (caused by redundant eyelid tissue).
- To treat periorbital sequelae of thyroid disease, facial paralysis, or nerve palsy that is causing a physical functional impairment, such as incomplete closure of the eye, and that has not resolved after adequate medical treatment.
- To relieve painful symptoms (severe squinting secondary to uncontrollable spasms of the periorbital muscles) of primary essential idiopathic blepharospasm when other treatments have failed. To repair or restore appearance that was damaged by an accidental injury (only the initial restorative repair is covered).

Blepharoptosis Repair

Blepharoptosis is the term used to describe drooping of one or both eyelids. Blepharoptosis repair is a surgical procedure performed on the levator muscle (the muscle that raises the upper eyelid) to correct a visual impairment caused by drooping of the eyelids and is a separate and distinct procedure from blepharoplasty.

Upper blepharoplasty and/or blepharoptosis repair may be medically necessary to remove excess upper eyelid tissue and/or repair a drooping eyelid causing a functional visual impairment when all the following criteria are met:

- Documented visual complaints, such as difficulty reading, walking, or driving.
- Visual field testing that indicates a significant loss of superior visual field. Each eye should be tested with the upper eyelid at rest and repeated with the upper eyelid skin and/or eyelid margin taped to demonstrate potential correction by the proposed procedure or procedures:
    - Visual field obstruction by the eyelid at rest must limit the upper visual field to within 30 degrees measured from the central fixation point.
    - The upper visual field must improve by at least 20 degrees with the redundant eyelid tissue and/or the upper eyelid taped (such that the eyelid margin assumes the anatomic position) to demonstrate potential correction by the proposed procedure or procedures.
- For upper blepharoplasty, frontal photographs demonstrating upper eyelid skin overhanging the upper eyelid margin and resting on the eyelashes. Lateral photographs to show redundant skin on the eyelashes should be submitted for review.

Ears

Total External Ear Reconstruction

Reconstruction is usually performed in stages. Each stage is spaced several months apart to allow for healing. Total external ear reconstruction does not include reconstruction of the external auditory canal.

Total external ear reconstruction may be medically necessary when the following criteria are met:

- Audiology evaluation and hearing testing document a significant hearing impairment and there is a likelihood that ear reconstruction will improve the hearing impairment.
- To facilitate the use of eyeglasses or a hearing aid.
- The patient has sufficient costal cartilage to carry out an optimal reconstruction. Generally, the costal cartilage is adequate by the time the patient is aged 9-10 years.

The congenital deformity (microtia) of the external ear (auricle) is considered medically necessary when criteria 1 or 2 and 3 are met. To repair or restore appearance that was damaged by accidental injury (only the initial restorative repair is covered) when skin quality in the auricular area secondary to burns or scarring does not prevent satisfactory results.

Reconstruction of the External Auditory Canal

Reconstruction may be medically necessary for the following:

- To repair congenital atresia (the maldevelopment or non-development of the ear canal) that is causing a significant hearing loss, and there is a likelihood that the procedure will improve the hearing impairment.
- To repair a deformed (e.g., stenotic) external auditory canal caused by disease or previous surgery when a significant hearing loss is documented.
- To repair or restore appearance that was damaged by accidental injury (only the initial restorative repair is covered).

Nose

Rhinoplasty

Rhinoplasty is a surgical procedure that is performed to change the shape and/or size of the nose or to correct a nasal defect. Rhinoplasty is most often performed for cosmetic purposes.

Rhinoplasty may be medically necessary to repair a chronic, nasal obstruction that directly causes a significant and symptomatic airway compromise, secondary to a congenital defect, disease, or tumor-ablative surgery, when all the following criteria are met:

- Photographic documentation (if there is an external nasal deformity) along with objective documentation that substantiates the severity of symptoms; and
- There are no other identifiable causes, e.g., polyps, allergies, turbinate hypertrophy, septal defect, or chronic lung disease; and
- Documentation that a reasonable trial of appropriate physician supervised conservative

treatment has failed.

Septoplasty

Septoplasty is a surgical procedure performed to correct a deformity (or deviation) of the nasal septum. This is most often a functional surgery that repairs altered anatomy of the nasal septum and does not alter the external appearance of the nose. Septoplasty is sometimes referred to as submucous resection of the septum (SMR) or septal reconstruction.

Septoplasty may be medically necessary to repair a deviated, perforated, or deformed septum that directly causes a significant and symptomatic airway compromise, recurrent nose bleeds, or recurrent sinusitis, secondary to a congenital defect, disease, trauma, or tumor-ablative surgery, when all of the following criteria are met:

- Objective documentation that substantiates the severity of symptoms. A deviated septum is readily apparent on a CT, however, obtaining a CT scan is not necessary in a patient in whom no other pathology is suspected (e.g., concomitant sinus disease).
- There are no other identifiable causes, e.g., polyps, allergies, turbinate hypertrophy, or chronic lung disease.
- Documentation that a reasonable trial of appropriate physician supervised conservative treatment has failed, including the duration and dose of the actual treatments, antibiotics, nasal steroids.

Craniofacial

Repair of Craniofacial Deformities

Holoprosencephaly (HPE)

HPE is a developmental defect of the embryonic forebrain, or prosencephalon, that is commonly associated with midfacial defects. The severity of the facial defect generally correlates to the severity of the brain defect.

Mild forms of HPE, or microform HPE, result in a spectrum of mild craniofacial anomalies with little to no CNS involvement or neurologic defects and can present with microcephaly, microphthalmia, ocular hypotelorism, midfacial hypoplasia, and cleft lip with or without cleft palate.

Moderate-to-severe forms of HPE (lobar, semilobar, and alobar HPE) are associated with a greater degree of CNS involvement and more severe craniofacial midline defects, such as a primitive nasal structure (proboscis), cyclopia (a single, midline eye), and midfacial clefting, as can be seen in the alobar subtype.

Severe HPE is not compatible with life, and these children generally do not survive beyond early infancy therefore, it is important that clinicians educate families about the spectrum of the disease and clinical outcomes.

The goals of reconstruction are to restore compromised skin, soft tissue, cartilage, and bone in order to establish functional and as close to normal appearance to the face and cranium. Correction of encephaloceles, deficient corneal protection, or cleft lip deformities are addressed in the neonatal period, whereas other surgical procedures, orthognathic interventions, and revisional surgeries can be performed over the next several years and into adolescence.

Surgical reconstruction of the midfacial defects is usually performed before two years of age in most patients with craniofacial deformities and disorders of feeding or respiratory difficulties. Surgical correction of most facial abnormalities in patients with severe defects is initiated at approximately 7 years of age when a significant facial growth has occurred. Surgical correction of the mandible is undertaken at 13 to 16 years of age as the jaw reaches dental and skeletal maturity. The most common congenital syndromes with craniofacial abnormalities include: Treacher-Collins syndrome, Pierre Robins Sequence, Nager Syndrome, Binder Syndrome and Shprintzen Syndrome.

Cleft Lip/Chin/Palate

Repair of Cleft Lip with or without Nasal Deformity (Cheiloplasty)

A surgical procedure to repair a cleft in the lip. Almost all children with a complete cleft lip and many with an incomplete cleft lip will have an associated nasal deformity. Primary cheiloplasty for cleft lip includes repair of a nasal deformity. It is unusual for the nasal deformity to be totally corrected during the primary repair and secondary rhinoplasty is usually required for complete correction of this deformity.

Primary repair of cleft lip with or without a nasal deformity may be medically necessary:

- To repair a congenital cleft lip, with or without a nasal deformity, that is causing a physical functional impairment, such as difficulty eating or drinking.
- For safe repair under general anesthesia, it is recommended that the child:
  - be at least 10 weeks of age
  - weigh 10 pounds, or more
  - have an Hgb of at least 10g
  - have a WBC count less than 10,000/mm

Secondary repair of cleft lip may be medically necessary:

- To revise a congenital cleft palate repair when there has been unfavorable healing, resulting in tightness or asymmetry causing a functional impairment. Secondary repair is accomplished by recreating the defect and closing it with a more satisfactory alignment.

Palatoplasty for cleft palate

A surgical procedure to repair a cleft in the soft and/or hard palate.

Primary palatoplasty is the initial cleft palate repair which is usually completed during the first year of life. Primary palatoplasty may be performed with or without soft tissue closure of alveolar ridge, and with or without bone graft (see Maxillary alveolar cleft repair with bone graft below).

Most Common Sequelae of cleft lip and/or palate:

- Nasolabial, oromaxillary, and/or oronasal fistula(s)
- Maxillary alveolar ridge cleft

Primary palatoplasty may be medically necessary:

- To repair a congenital cleft palate that is causing a physical functional impairment. A

cleft palate may impair feeding, speech impairments (hypernasal speech) and dental development.

Secondary palatoplasty may be medically necessary:

- To repair a congenital cleft palate repair that is causing a physical functional impairment, such as velopharyngeal incompetence (hypernasal speech).

Revision palatoplasty with pharyngeal flap repair should be done when it is absolutely clear that palate function is inadequate, and speech has not improved with speech therapy. This flap can have a profound effect on breathing. Airway compromise in patients who undergo pharyngeal flap palatoplasty can be a potentially fatal complication.

Maxillary alveolar cleft repair with bone graft

A cleft of the dental ridge (gum line) of the upper jaw (maxilla) that commonly occurs in children with facial clefts.

Maxillary alveolar cleft ridge repair may be medically necessary:

- To repair a congenital maxillary alveolar cleft that is causing a physical functional impairment, such as, when the cleft impairs normal dental development.

Repair of Nasolabial, Oromaxillary, and/or Oronasal fistula(s): Some children with cleft palates, with or without cleft lips will be left with a fistula after the primary repair. In some cases, the fistula is left intentionally, in other cases it has developed because of poor healing. Fistulas may also be caused by infection, trauma or as a complication of removing a tooth.

Repair of nasolabial, oromaxillary, and/or oronasal fistula(s) may be medically necessary:

- To repair a fistula that is causing a physical functional impairment, such as difficulty eating or drinking or when the fistula impairs speech.

Facelift

Rhytidectomy

A surgical procedure to remove redundant (excess) skin from the facial area. This procedure is commonly known as a facelift.

Rhytidectomy may be medically necessary:

- To restore appearance that was damaged by accidental injury (only the initial restorative repair is covered).
- To repair a physical functional impairment secondary to a congenital defect or birth abnormality, accidental injury, prior surgical procedure, or disease (e.g., facial paralysis or nerve palsy. A functional impairment may occur when excess skin impairs eating and drinking.

Chin

Mentoplasty

Mentoplasty refers to plastic surgery procedures for the chin and may be medically necessary:

- To repair or restore appearance that was damaged by accidental injury (only the initial

restorative repair is covered).

- To improve or correct a physical functional impairment (the ability to speak or chew normally) resulting from a congenital defect or birth abnormality, accidental injury, prior surgical procedure, or disease. Dental history and x-rays of the head and jaw are necessary in order to determine whether the impairment can be corrected by a chin implant, augmentation, or reduction.
- In conjunction with a covered orthognathic surgery to correct deformities of the jaw which causes a functional impairment in chewing or speaking which has not been resolved by speech or oral therapy.

Skin Procedures

Tattooing

Tattooing is the introduction of insoluble pigments via sterile needle to correct color defects of the skin.

Tattooing may be medically necessary:

- To repair or restore appearance of skin of the face (scar or burn camouflage) that has been damaged by accidental injury (only the initial restorative repair is covered).
- For the creation of a more natural appearance to the nipple-areola complex following breast reconstruction surgery.

The removal of a positional tattoo place to facilitate radiation therapy may be medically necessary, however the placement of tattoos in conjunction with radiation therapy is not separately reimbursable.

Scar Treatment and Scar Revision

The timing of scar treatment is variable; however, no scar can ever be completely removed. Without revision, most scars will show some improvement within 1 to 3 years. Uneven, poorly positioned scars or ones with marked step-off may be revised as early as 2 months after the original closure. Early intervention by revision with realignment of the scar may allow for rapid maturation and improved healing.

Scar revision may be medically necessary:

- When the scar is the result of accidental injury or 3rd degree burns (the injury must have taken place on or after the member's effective date.
- When the scar causes a physical functional impairment (i.e., the scar interferes with the movement of the mouth, a joint, or when the scar is associated with symptoms of intense pain, burning, or itching that cannot be effectively treated with local and or systemic medication, such as analgesics, corticosteroids or antibiotics).
- When the scar has a history of intermittent breakdown with bleeding.

The following scar revision techniques may be used:

- Tissue transfer (i.e., flaps and grafts)

- Scar re-excision
- Scar rearrangement (i.e., Z-plasty, W-plasty)
- Abrasion or dermabrasion
- Pulsed dye, CO2 or YAG laser
- Intralesional corticosteroid injections

Several techniques may be needed to minimize a scar and improve the functional impairment is causes.

Panniculectomy, abdominoplasty, lipectomy and liposuction

Panniculectomy and Abdominoplasty

- Considered medically necessary when the following criteria is met:
  - Grade pannuculus or pannuculus that extends below the level of the pubic symphoysis as documented in photographs with high-quality color image(s) of the physical/physiologic abnormality; and
  - Medical records (including consultations or any other pertinent information) document ONE or more of the following:
    - Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment; or
    - Non-healing ulceration under panniculus, chronic maceration or necrosis of overhanging skin folds, recurrent or persistent skin infection under panniculus, intertriginous dermatitis or cellulitis or panniculitis, recurrent/chronic rashes, infections, cellulitis, or non-healing ulcers, that don't respond to conventional treatment (e.g., dressing changes, topical, oral or systemic antibiotics, corticosteroids or antifungals) for a period of 3 months; or
    - difficulty ambulating, limitations in physical activity and interference with daily living activities; or
    - functional impairment requiring physical therapy, pharmotherapy or related treatment for a period of 3-6 months
      - Panniculus causes limitations in ambulation or physical activity
      - Panniculus interferes with ADLs
      - Nonhealing ulceration under panniculus
      - Chronic maceration or necrosis of overhanging skin folds
      - Recurrent or persistent skin infection under panniculus
      - Intertriginous dermatitis or cellulitis or panniculitis

    and
  - There is a presence of functional deficit due to a severe physical deformity or disfigurement resulting from the pannus; **and**

- Symptoms or functional impairment persists despite significant* weight loss which has been stable for at least 6 months or well-documented attempts at weight loss (medically supervised diet or bariatric surgery) have been unsuccessful.
- *Significant weight loss varies based on the individual clinical circumstances and may be documented when the individual:
  - Reaches a body mass index (BMI) less than or equal to 30 kg/m2; or
  - Has documented at least a 100-pound weight loss; or
  - Has achieved a weight loss which is 40% or greater of the excess body weight that was present prior to the individual's weight loss program or surgical intervention.

  and
- If the individual has had bariatric surgery, he/she is at least 18 months post-operative or has documented stable weight for at least 3 months.
- Surgery is expected to restore or improve the functional deficit or deformity.

NOTE: In the absence of this documentation, the surgery or procedure must be considered cosmetic.

- Panniculectomy is considered medically necessary as an adjunct to a medically necessary surgery when needed for exposure in extraordinary circumstances.
- Panniculectomy is considered not medically necessary for ANY other indication.
- Abdominoplasty is considered cosmetic and not medically necessary for any indication.

Diastasis Recti

Diastasis Recti Abdominis Repair

The separation of the left and right side of the rectus abdominis muscle. Diastasis recti abdominis occurs primarily in pregnant women and newborns but may also occur in patients with chronic obstructive pulmonary disease, following abdominal surgery, or with obesity.

Diastasis recti abdominis repair may be medically necessary:

- If a hernia develops and becomes trapped in the space between the muscles. The recti abdominis muscle may be repaired at the time of the hernia repair to prevent recurrence.

Lipectomy and Liposuction

- Considered medically necessary when the following criteria are met:
  - When performed in the treatment of lymphedema (i.e., related to surgical mastectomy); or
  - There is significant functional impairment or medical complication (i.e., difficulty ambulating or performing daily functions); AND
  - Procedure is expected to improve functional impairment (i.e., volume reduction resulting in significant mobility improvement); AND

- Patient has not responded to at least 3 consecutive months of appropriate treatment (i.e., treatment with compression garments, complex/complete decongestive therapy (CDT) or manual lymph drainage); AND
- Treatment plan requires patient to wear compression garments as instructed and continue postoperative treatment to maintain benefit.

- Considered cosmetic and not medically necessary when:
  - Performed in the absence of a significant functional impairment; or
  - When medically necessary criteria in Section A above is not met
- Suction-assisted lipectomy used in conjunction with a panniculectomy is considered integral to the primary procedure and will not be separately reimbursed.

Brachioplasty (arm lift), Buttock and Thigh Lift

- Considered medically necessary when:
  - Performed due to significant functional impairment (i.e., excessive skin that interferes with daily living or causes persistent cellulitis, dermatitis, or skin ulcerations); or
  - Impairment persists despite appropriate treatment; or
  - Procedure is expected to improve functional impairment.
- Considered cosmetic and not medically necessary when:
  - Performed in the absence of a significant functional impairment; or
  - When procedure will not improve a significant functional impairment

BREAST

Reduction Mammoplasty (when unrelated to breast cancer)

Reduction mammoplasty or breast reduction surgery involves removal of skin, fat and glandular breast tissue and is a surgical procedure designed to relieve the associated clinical symptoms resulting from breast hypertrophy (an increase in the volume of weight of breast tissue in excess of the normal proportion).

- Reduction Mammoplasty is considered medically necessary when there is a presence of the following and other etiologies are excluded:
  - Chronic upper back pain;
  - Chronic neck pain;
  - Chronic shoulder pain;
  - Breast pain from excessive breast tissue;
  - Numbness of breasts, hands, or arms in which interference with daily activities or work has been documented in the clinical records. The pain is clearly related to the excess weight of the breast tissue and there has been at least three (3) months of adequate conservative treatment with one or more of the following special support

garments (for example, special support bras, bras with wide straps, etc.), NSAIDs, physical therapy or similar modality; OR

- Permanent shoulder grooving with ulceration from bra straps;
- Persistent intertrigo of the inframammary folds that has not responded to at least three (3) months of adequate conservative treatment. Medical records from the primary care physician and other providers (for example, physiatrist, orthopedic surgeons, etc.) who have diagnosed or treated the symptoms prompting this request may also be required.

- The estimated amount of excess breast tissue to be removed should be indicated. Patient's breasts must be fully grown (i.e., breast size stable for approximately one (1) year) and removal of more than 500 grams of tissue from each breast is anticipated. The preoperative evaluation by the surgeon concludes that an appropriate amount of breast tissue from at least one breast will be removed based upon body surface area or total mass to be removed and that there is a reasonable prognosis of symptomatic relief. The request for surgery must include:
  - The individual's height and weight;
  - The size and shape of the breast(s) causing symptoms;
  - The anticipated amount of breast tissue to be removed.

  Note: Pictures may be requested to document medical necessity.
- Breast reduction surgery is considered cosmetic and not medically necessary for the following conditions:
  - Poor posture
  - Breast asymmetry
  - Pendulousness
  - Problems with clothes fitting properly
  - Nipple-areola distortion

The use of liposuction to perform breast reduction is considered not medically necessary.

Breast Reconstructive Surgery (when unrelated to breast cancer)

- Reconstructive Breast Surgery to rebuild the normal contour of the affected and the contralateral unaffected breast to produce a more normal appearance following a mastectomy, lumpectomy or other breast surgery for breast cancer is mandated for coverage by the Women's Health and Cancer Rights Act of 1998 (WHCRA). Breast surgery procedures for the treatment of significant abnormalities related to trauma, infection, or congenital defects such as Poland Syndrome, gynecomastia in men or other non-malignant disease may be considered medically necessary.
  - The Surgical Treatment of Gynecomastia (the benign enlargement of the male breast, either due to increased adipose tissue, glandular tissue, fibrous tissue, or a combination of all three) is considered medically necessary when ALL of the following criteria are met:

- Male is over 18 years of age with significant breast tissue present for over two years; AND
- Excess breast tissue is glandular and not fatty tissue as confirmed by physical exam, mammogram, and/or tissue pathology; AND
- Excess breast tissue growth is not due to illicit drugs such as marijuana or anabolic steroids; AND
- Other causes have been ruled out, medical conditions of hormonal imbalances or reversible drug treatments; AND
- If caused by obesity (BMI > 30), there is documentation of failure of conservative treatment with clinically supervised, comprehensive weight loss program for at least 6 months; AND
- There is documented significant medical breast symptoms unresolved by conservative treatment.

- Removal of Breast Implants (any type) with or without capsulotomy or reimplantation is considered reconstructive and medically necessary when:
  - An implant was originally placed in an individual with a history of mastectomy, lumpectomy, or treatment of breast cancer for reconstructive purposes as defined above and there is a documented silicone implant rupture on imaging (that is, using mammography, ultrasound, or MRI); and/or including for the purpose of producing a symmetrical appearance of the non-diseased breast.
  - There has been development of a visible distortion (Baker Class IV capsular contracture).
  - There is acute persistent or recurrent local infection secondary to a breast implant, when there is failure, contraindication or intolerance to medical management including antibiotics.
  - Exposure of a breast implant or tissue necrosis secondary to the implant
  - The implant is interfering with the diagnostic evaluation of a suspected breast cancer or impairs adequate treatment of known breast cancer (e.g., obstructing radiation therapy)
  - For the diagnosis of breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) or current use of Allergan BIOCELL textured breast implants and tissue expanders or diagnosis of breast implant-associated squamous cell carcinoma (BIA-SCC
- In patients without a history of breast cancer, the removal of silicone gel-filled breast implants with or without capsulotomy is considered medically necessary when rupture of the implant and or extrusion of the silicone implant contents have been confirmed on imaging studies. Silicone gel-filled implants may rupture as the result of the age of the implant, the presence of a capsular contracture, or trauma.
- Removal of ANY TYPE of intact breast implant for the following is considered not medically necessary when:
  - Systemic symptoms attributed to connective tissue disease, or autoimmune

diseases;

- Personal anxiety; to treat psychological symptomatology or psychosocial complaints;
- Pain not related to contractures or rupture;
- Solely to improve appearance because of shifting or migration of the implant that was inserted for cosmetic purposes only.

- Removal of a ruptured saline-filled or “Alternative” implant is considered not medically necessary since the potential adverse medical consequences of implant rupture are related to silicone gel implants only. However, the following exception applies:
  - Allergan (formerly Inamed) Natrelle Saline Breast Implants (P020056 and P990074). In July 2019, Allergan voluntarily recalled Natrelle BIOCELL textured breast implants and tissue expanders from the market to protect patients from breast implant-associated anaplastic large cell lymphoma (BIA-ALCL). Smooth surfaced implants are not affected by this recall (FDA, 2021).
- Surgery on the contralateral breast to produce a symmetrical appearance after removal of a ruptured or implant and reimplantation is considered reconstructive when the implant was originally placed for reconstructive purposes in an individual with a history of mastectomy, lumpectomy, or treatment of breast cancer.
- Reimplantation of an implant inserted for cosmetic purposes only, or other breast procedures, (including augmentation mammoplasty/breast lift, implant repositioning, repair of inverted nipples, mastopexy (breast lift surgery designed to lessen the degree of breast ptosis (sagging)) are considered cosmetic and not medically necessary except when performed as part of a covered breast reconstruction service. Mastopexy is not a covered benefit (except following a mastectomy).

Exclusions of Breast

- Removal of intact breast implants for suspected autoimmune or connective tissue disease or for breast cancer prevention because these indications are considered experimental and investigational.
- Removal of an intact breast implant that has shifted. Implant shifting in the absence of refractory infection or Stage IV capsular contracture is not medically necessary.
- Benefits for reconstructive procedures include breast reconstruction for the diagnosis of Breast Cancer following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other covered health care service as required by the Women's Health and Cancer Rights Act of 1998. However, if the original service was not a covered benefit under the CountyCare Medical Policy or applicable guidelines, (e.g., cosmetic, investigational, not a covered health service, etc.), then benefits are limited to the treatment of the complication. Examples include but are not limited to removal of a leaking, ruptured or defective silicone breast prosthesis is a covered health care service. However, benefits for replacement of the breast prosthesis are only available if the original prosthesis was considered "reconstructive” and not “cosmetic.”

LIMITATIONS

- When a medical problem results from covered or non-covered cosmetic procedures, medically necessary services required to treat the medical problem will be determined by the health plan.
- Common, anticipated side effects of cosmetic surgery (e.g., nausea and vomiting which result in a prolonged hospital stay) are considered part of the cosmetic surgery procedure and are not eligible for additional coverage.

EXCLUSIONS

The following Cosmetic procedures are excluded from coverage:

- Pharmacological regimens, nutritional procedures, or treatments for the improvement of physical appearance
- Scar or tattoo removal or revision procedures (such as salabrasion, microdermabrasion or chemosurgery and other such skin abrasion procedures) for the improvement of appearance unrelated to accidental injury or 3rd degree burns
- Skin abrasion procedures performed as a treatment for acne, treatments for acne scarring including, but not limited to subcutaneous injections to raise acne scars, chemical exfoliation, and dermabrasion, treatments for active acne are not covered: acne surgery, cryotherapy for acne (CPT code 17340), chemical exfoliation for acne (CPT code 17360), and laser and light based therapies, including but not limited, to blue light therapy, pulsed light, and diode laser treatments
- Otoplasty for protruding ears with or without size reduction is considered cosmetic and not medically necessary and is therefore not covered
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to reconstructive liposuction
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin
- Subcutaneous injection of filling materials such as bovine collagen is not covered for the treatment of acne or chicken pox scars, facial wrinkles, or any other cosmetic purposes
- Treatment for spider veins
- Sclerotherapy treatment of veins solely for the purpose of improving appearance
- Hair removal by any method, temporary or permanent, including, but not limited to, electrolysis, waxing, or laser hair removal, is cosmetic and not covered, even if the excessive hair is caused by a medical condition. However, hair removal may be covered as part of genital reconstruction prescribed by a physician for the treatment of gender dysphoria. (For laser or electrolysis hair removal in advance of genital reconstruction, please refer to the CountyCare Medical Prior Authorization Policy PA.205.CC Surgical Treatment of Gender Dysphoria)

- Breast Reduction or Breast Lifts as a treatment to psychosocial complaints, psychological symptomatology or for the sole purpose of improving appearance
- Brachioplasty (arm lift), Buttock and Thigh Lift, Lipectomy and Liposuction when performed in the absence of a significant functional impairment or when not expected to improve a significant functional impairment
- Services related to cosmetic surgery, cosmetic treatments, and cosmetic procedures are not covered. This includes but is not limited to physician charges, hospital charges, charges for anesthesia, drugs, or dressings

CODING AND STANDARDS

In addition to the codes listed below, see Schedule A for additional examples of procedures and services considered to be cosmetic in nature and therefore not covered (except when otherwise indicated).

Codes

Code	Description
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)

Code	Description
15786	Abrasion; single lesion (e.g., keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
17380	Electrolysis epilation, each 30 minutes
21270	Malar augmentation, prosthetic material
69090	Ear piercing
69300	Otoplasty, protruding ear, with or without size reduction
J0591	Injection, deoxycholic acid, 1 mg
The following codes require review to determine whether they are cosmetic or reconstructive:	
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less

Code	Description
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)
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm

Code	Description
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
15570	Formation of direct or tubed pedicle, with or without transfer; trunk
15572	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs
15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15730	Midface flap (i.e., zygomaticofacial flap) with preservation of vascular pedicle(s)
15731	Forehead flap with preservation of vascular pedicle (e.g., axial pattern flap, paramedian forehead flap)
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (i.e., buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk
15736	Muscle, myocutaneous, or fasciocutaneous flap; upper extremity
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity
15740	Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel
15756	Free muscle or myocutaneous flap with microvascular anastomosis
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)

Code	Description
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
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
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
15877	Suction assisted lipectomy; trunk [when specified as abdominal liposuction]
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

Code	Description
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue [when specified as other abdominoplasty, excision excessive skin and subcutaneous tissue, including lipectomy, of abdomen]
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with implant
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21181	Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm

Code	Description
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (e.g., micro-ophthalmia)
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach

Code	Description
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach
21275	Secondary revision of orbitocraniofacial reconstruction
21295	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach
21296	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach
21299	Unlisted craniofacial and maxillofacial procedure
28344	Reconstruction, toe(s); polydactyly
30540	Repair choanal atresia; intranasal
30545	Repair choanal atresia; transpalatine
30560	Lysis intranasal synechia
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)
L8600	Implantable breast prosthesis, silicone or equal
L8607	Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies
Q2026	Injection, Radiesse, 0.1 ml
Q2028	Injection, sculptra, 0.5 mg

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☐	Commercial
☐	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

BACKGROUND

The American Society of Plastic Surgeons (ASPS) defines a **reconstructive service** as a procedure or surgery that is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve functions but may also be done to approximate a normal appearance. These services differ from **cosmetic services**, which ASPS defines as surgical and nonsurgical procedures that reshape normal structures of the body to improve appearance and self-esteem.

Note: Coverage of reconstructive procedures is decided based on the applicable definition of medical necessity of the member's type of insurance and the Clinical Guidelines, Medical Payment Guidelines or Pharmacy Guidelines which govern the procedure or service.

POLICY HISTORY

Date	Summary
November 20, 2025	• This guideline replaces MP.079.CC Cosmetic and Reconstructive Procedures • Editorial changes to match the formatting and layout of the new template, no changes to clinical content

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Administrative Services Medical Policy Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

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ATTACHMENT A

Cosmetic and Reconstructive Procedures

The following list contains additional examples of procedures and services considered to be cosmetic in nature and therefore **not** covered, except when indicated in the identified Clinical Guidelines, Medical Payment Guidelines or Pharmacy Guidelines in Column III.

This list should not be considered all inclusive. The following codes for treatments and procedures applicable to this policy are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

I	II	III
Procedure	**Codes for Procedures in Column I – NOT covered**	**Exception for Coverage**
Acne, treatment of acne cysts and Acne, comedone extraction/treatment	10040 Acne surgery (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules) 17340 Cryotherapy (CO2 slush, liquid N2) for acne 17360 Chemical exfoliation for acne (e.g., acne paste, acid)	
Actinic keratosis, destruction, unless suspicious of malignancy	Informational only No codes for configuration because of potential medical necessity	
Age spot treatments (**SEE**: Skin lesions, excision of benign)		
Alopecia treatment (**SEE**: Hair Transplant)		This may be reviewed on a case-by-case basis for medical necessity.

Procedure	Codes for Procedures in Column I – NOT covered	Exception for Coverage
Arm, forearm, hand lift (**SEE**: Lipectomy)		
Birthmark/ blemish treatment (**SEE**: Skin lesions, excision of benign)		
Blepharoplasty lower lid	15820 Blepharoplasty, lower eyelid lid 15821 Blepharoplasty, lower eyelid lid with extensive herniated fat pad	
Body contouring after major weight loss for men (**SEE**: Lipectomy)		
Body lift (**SEE**: Lipectomy)		
Body piercing	No specific code for this	
Botox treatments		**SEE**: EVH_CG_5004.CC - OnabotulinumtoxinA (Botox®), AbobotulinumtoxinA (DysportTM), RimabotulinumtoxinB (Myobloc®), and IncobotulinumtoxinA (Xeomin®)
Breast asymmetry, correction of. *Except in the case of breast cancer*		
Breast reconstruction.		

Procedure	Codes for Procedures in Column I – NOT covered	Exception for Coverage
Except in the case of breast cancer		
Breast augmentation/lift/implants. *Except in the case of breast cancer*		
Breast reduction		
Breast repositioning		
Brow lift/ptosis repair		
Buttock lift (**SEE**: Lipectomy)		
Cheek implant (SEE: Malar (facial) implants)		
Chemical peel	15788 Chemical peel, facial; epidermal 15789 Chemical peel, facial; dermal 15792 Chemical peel, nonfacial; epidermal 15793 Chemical peel, nonfacial; dermal	
Chest wall deformity, congenital (pectus excavatum, pectus carinatum) when asymptomatic	No specific code for this	Treatment for pectus excavatum is considered medically necessary when the member has a Haller score of 3.25 or higher on Computed Tomography (CT) scan. Treatment for pectus carinatum is considered medically necessary when member has symptoms indicating medical necessity for

Procedure	Codes for Procedures in Column I – NOT covered	Exception for Coverage
		surgery which include severe shortness of breath on minimal exertion, reduced endurance, and exercise-induced asthma.
Chin implant or surgery for deformity, not cause by trauma or accidental injury (**SEE**: Genioplasty)		
Cleft Lip/Chin/Palate		Covered as outlined above
Collagen replacement therapy: injections or implants	11950 Subcutaneous injection of filling material (e.g., collagen): 1cc or less 11951 1.5 to 5 cc 11952 5.1 to 10 cc 11954 10 cc or more	
Comedone acne extraction (**SEE:** Acne)		
Congenital abnormalities without functional impairment	No specific code for this	
Craniofacial Deformity Repair		Covered as outlined above
Dental congenital abnormalities	No specific code for this	
Dermoid cyst (when not medically necessary)	30124 Excision of dermoid cyst, nose: simple, skin, subcutaneous	

Procedure	Codes for Procedures in Column I – NOT covered	Exception for Coverage
Dermabrasion	15780 Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis) 15781 Dermabrasion; segmental, face 15782 Dermabrasion; regional, other than face 15783 Dermabrasion; superficial, any site, (e.g., tattoo removal)	
Dermal filler and volume producing agents (i.e., Sculptra, Radiesse)	G0429 Derm filler injection for treatment facial lypodystrophy Q2026 Injection, Radiesse 11950 Subcutaneous injection of filling material (e.g., collagen); 1 cc or less 11951 Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc 11952 Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc 11954 Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc	
Dermoscopy	No specific code for this	
Ear piercing	69090 Ear piercing	
Ear protrusion correction (**SEE**: Otoplasty)		
Electrolysis epilation /hair removal (**SEE**: Hair Removal)		
Excision of redundant (excess) skin and subcutaneous tissue of the hips, thighs, buttocks, arms, and other anatomical areas when there is not a functional physical impairment		

Procedure	Codes for Procedures in Column I – NOT covered	Exception for Coverage
(**SEE:** Lipectomy)		
Excision/surgical planing of skin of nose for rhinophyma (**SEE:** Rhinophyma)		
Facial & nasal implants	D5913 Nasal prosthesis D5919 Facial prosthesis D5925 Facial augmentation implant prosthesis D5926 Nasal prosthesis replacement D5929 Facial prosthesis replacement	
Eyelid surgery (Blepharoplasty, brow lifts, ptosis repair)		
Face lift or related procedures to diminish the aging process (**SEE**: Rhytidectomy)		
Fat graft, unless an integral part of another covered procedure		
Forehead lift (**SEE**: Rhytidectomy)		
Frown Line reduction (Refer to Glabella)		
Genioplasty (**SEE**: Rhytidectomy and Lipectomy)	21120 Genioplasty: augmentation (autograft, allograft, augmentation)	
Glabella/Glabelloplasty (frown lines), excision/correction	21137 Reduction forehead; contouring only	

Procedure	Codes for Procedures in Column I – NOT covered	Exception for Coverage
(**SEE**: Rhytidectomy)	21138 Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft) 21139 Reduction forehead; contouring and setback of anterior frontal sinus wall	
Gynecomastia reduction/ treatment		
Hair Removal (hirsutism)	17380 Electrolysis epilation, each 30 minutes	
Hair Transplant (Hairplasty) or repair of any congenital or acquired hair loss, including hair analysis	15775 Punch graft for hair transplant; 1 to 15 punch grafts 15776 Punch graft for hair transplant; more than 15 punch grafts	
Hemangioma treatment *Except when atypical or causing functional limitation (i.e., affects vision, breathing, hearing, ability to eat, bleeding, ulceration, and/or infection.*	17106 Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm	
Hip Lift (**SEE**: Lipectomy)		
Hyperhidrosis surgery including endoscopic transthoracic sympathecotomy (ETS), sympathectomy (radial artery, ulnar nerve, superficial palmar arch), video assisted thoracic sympathectomy (VATS)		
Injectable fillers		

Procedure	Codes for Procedures in Column I – NOT covered	Exception for Coverage
(**SEE**: Dermal fillers)		
Insertion or injection of prosthetic material to replace absent adipose tissue. *Except for breast cancer*		
Keloid scar treatment (**SEE**: Scar Revision)		
Labial reduction / labiaplasty	No specific code for this	
Laser band-aid face lift	No specific code for this	
Laser facial resurfacing (**SEE**: Dermabrasion)	No specific code for this	
Laser hair removal (**SEE:** Hair Removal)		
LAVIV™ (azfibrocel-T) injections	No specific code for this	
Leg lift (**SEE:** Lipectomy)		
Lipectomy (including suction lipectomy)	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	

Procedure	Codes for Procedures in Column I – NOT covered	Exception for Coverage
	15836 Excision, excessive skin, and subcutaneous tissue (includes lipectomy); arm 15837 Excision, excessive skin, and subcutaneous tissue (includes lipectomy); forearm or hand 15838 Excision, excessive skin, and subcutaneous tissue (includes lipectomy); submental fat pad 15839 Excision, excessive skin, and subcutaneous tissue (includes lipectomy); other area	
Liposuction unless an integral part of another covered 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	
Malar (facial) implants	No specific code for this	
Mastopexy (breast lift for pendulous breasts)		
Mentoplasty (**SEE**: Genioplasty)		
Moles /nevi, excision *Except when medically necessary when there is clinical suspicion for pre-cancerous or cancerous lesions.*	No specific code for this	
Neck tuck or lift (**SEE**: Lipectomy and Rhytidectomy)		

Procedure	Codes for Procedures in Column I – NOT covered	Exception for Coverage
Moon face correction (as a result of corticosteroid therapy)	No specific code for this	
Nasal septum cartilage graft	20912 Cartilage graft, nasal septum	
Obesity surgery		**SEE:** EVH_CG_2707.CC – Bariatric Surgery
Orthodontic treatment, even when provided along with reconstructive surgery	No specific code for this	
Otoplasty	69300 Otoplasty, protruding ear, with or without size reduction	
Pectus excavatum repair when asymptomatic (**SEE**: Chest wall deformity)		
Permanent makeup (**SEE**: Tattoo)		
Port wine stain treatment *Except when atypical or causing functional limitation (i.e., affects vision, breathing, hearing, ability to eat, bleeding, ulceration, and/or infection.* (**SEE**: Hemangioma treatment)		
Radial keratotomy when defect can be corrected with lenses	65771 Radial Keratotomy	

Procedure	Codes for Procedures in Column I – NOT covered	Exception for Coverage
Rhinoplasty	30400 Rhinoplasty; primary; lateral & alar cartilages and/or elevation of nasal tip 30410 Rhinoplasty; complete; external parts including bony pyramid; lateral & alar cartilages &/or elevation of nasal tip. 30450 Rhinoplasty, secondary, major revision	
Refractive keratoplasty/eye surgery (LASIK, PTK)	65760 Keritomileusis (LASIK) 65765 Keratophakia 65767 Epikeritoplasty	
Rhinophyma treatment/excision	30120 Excision or surgical planing of skin of nose for rhinophyma	
Removal of unwanted/excessive hair growth (**SEE:** Hair Removal)		
Rhytidectomy (face, chin, neck, browlift)	15824 Rhytidectomy; forehead 15825 Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap) 15826 Rhytidectomy; glabellar frown lines 15828 Rhytidectomy; cheek, chin, and neck 15829 Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	
Rosacea, treatment of (including erythema, telangiectasia)	Codes are the same as Hemangioma	

Procedure	Codes for Procedures in Column I – NOT covered	Exception for Coverage
Except when atypical or causing functional limitation		
Salabrasion (tattoo removal) (**SEE:** Tattoo)		
Scar revision *Except when atypical or causing functional limitation (i.e., affects vision, breathing, hearing, ability to eat, bleeding, ulceration, and/or infection.*	15786 Abrasion; single lesion (e.g., keratosis, scar) 15787 Abrasion; each additional four lesions or less	Burn scars in children when medically necessary
Sclerosing of Spider Veins (**SEE:** Spider vein removal/repair)		
Septoplasty		
Septorhinoplasty		
Skin discoloration (including dyschromia, and treatment)	No specific code for this	
Skin lesions, excision of benign *Except when atypical or causing functional limitation (i.e., affects vision, breathing, hearing, ability to eat, bleeding, ulceration, and/or infection; OR* *Except when medically necessary when there is clinical suspicion for pre-*	Informational only No codes for configuration because of potential medical necessity	

Procedure	Codes for Procedures in Column I – NOT covered	Exception for Coverage
cancerous or cancerous lesions.		
Skin removal for excessive/redundant skin. *Except for breast cancer* (**SEE:** Lipectomy)		
Skin rejuvenation and resurfacing (**SEE:** Dermabrasion)	No specific code for this	
Spider vein removal/repair, including telangiectasia and stellate angioma	36468 Single or multiple injections of sclerosing solutions, spider veins (telangiectasia), limb or trunk	
Skin tag removal, Except when atypical or causing functional limitation (i.e., affects vision, bleeding, ulceration, and/or infection.	Informational only No codes for configuration because of potential medical necessity	
Subcutaneous injection of filling material (e.g., Restylane, Collagen, Hyaluronic acid) (**SEE:** Dermal fillers)		
Surgical repair of inverted nipple		
Tattoo (decorative or self-induced) removal/treatment	No specific code for this	
Thigh lift (**SEE**: Lipectomy)		

Procedure	Codes for Procedures in Column I – NOT covered	Exception for Coverage
Temporal Mandibular Joint (TMJ), non-surgical treatment		
Tissue expansion, when not medically necessary		
Torn earlobe repair	No specific code for this	
Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)	49250 Umbilectomy, omphalectomy, excision of umbilicus	
Varicose veins, removal of spider veins (telangiectasia)		
Voice lifting procedures (To restore voice to youthful quality, implants, injections of fat or collagen)		
XEOMIN® (incobotulinumtoxinA) injections when used to improve the appearance of glabellar lines		**SEE:** EVH_CG_5004.CC - OnabotulinumtoxinA (Botox®), AbobotulinumtoxinA (DysportTM), RimabotulinumtoxinB (Myobloc®), and IncobotulinumtoxinA (Xeomin®)