Clinical Policy: Cosmetic and Reconstructive Procedures

Reference Number: LA.CP.MP.31c
Date of Last Revision: 11/23

Coding Implications
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. Cosmetic procedures or procedures connected with cosmetic surgery are not reimbursable. The Centers for Medicare and Medicaid Services (CMS) define cosmetic procedures as "a procedure that is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem." These procedures can be performed for medically necessary or cosmetic reasons.
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 Louisiana Healthcare Connections 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 (unless conservative therapy is not standard of care for the condition, or is contraindicated);
   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*, medically necessary lumpectomy, or other medically necessary breast surgery 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 [Poly-L-Lactic acid (Sculptra™), calcium hydroxylapatite microspheres (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 (LDS);

   Note: Please refer to LA.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.

5. *Note: This includes reconstruction after a therapeutic intervention (e.g., mastectomy) or trauma resulting in significant loss of breast tissue:
   a. Reconstruction of the affected breast;
   b. Reconstruction of the contralateral breast to produce a symmetrical appearance;
   c. Prostheses (implanted, external, or both); and
      Treatment of complications of the reconstructionAll prosthetic implants must be FDA approved and used in compliance with all FDA requirements at the time of the surgery.
6. If an indication for medically necessary removal of breast implants is present unilaterally, removal of the contralateral breast implant is also considered medically necessary when performed during the same operative session. Removal of breast implants for purposes other than reconstruction is considered medically necessary for the following indications:
   a. Visible capsular contracture causing pain (Baker Grade IV)
   b. Diagnosed or suspected implant rupture
   c. Local or systemic infection
   d. Siliconoma or granuloma
   e. Implant extrusion
   f. Interference with the diagnosis or treatment of breast cancer
   g. Breast implant-associated anaplastic large cell lymphoma

II. It is the policy of Louisiana Healthcare Connections 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 clinical decision support criteria
F. Surgery to correct unsatisfactory results from previous cosmetic and/or non-covered service
G. Removal of excess skin or body contouring procedures following weight loss or bariatric surgery when removal is solely cosmetic
H. Facial augmentation
I. Abdominoplasty
J. Dermabrasion
K. Skin rejuvenation and resurfacing
L. Electrolysis, laser hair removal
M. Hair transplantation, when not performed to correct permanent hair loss caused by disease or injury
N. Tattooing (except when covered for breast reconstruction post-mastectomy)
O. Injectable filler
P. Circumcision revisions done only to improve appearance

Q. Mastopexy (except for breast reconstruction post-mastectomy, medically necessary lumpectomy, or other medically necessary breast surgery resulting in significant asymmetry)
R. Correction of inverted nipples
S. Repair of diastasis recti
T. Breast reconstruction for fibroadenomas or other benign lesions, unless medically necessary per clinical decision support criteria.
U. Reduction mammoplasty removal of breast implants are considered cosmetic and not medically necessary When the procedure is not reconstructive and is performed solely for the purpose of altering the appearance of the breast *(For specific criteira Refer to Reduction Mammoplasty and Gynecomastia Surgery, LA.CP.MP.51)*

III. Reimbursement
Louisiana Healthcare Connection code editing software will review claim lines to determine if a procedure code is potentially cosmetic in nature. If a procedure code is identified, the current claim and claims history will be reviewed (prior to payment) by a clinical review nurse to determine if the procedure appeared to be purely cosmetic in nature.

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.[2] 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.[3]

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.[1]

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 2022, 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 and may not support medical necessity. 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.

NOTE: Coverage is subject to each requested code's inclusion on the corresponding LDH fee schedule. Non-covered codes are denoted (*) and are reviewed for Medical Necessity for members under 21 years of age on a per case basis.

CPT Codes That Support Coverage Criteria

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)
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
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

CPT Codes Codes	Description
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
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)
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)
15775*	Punch graft for hair transplant; 1 to 15 punch grafts
15776*	Punch graft for hair transplant; more than 15 punch grafts

CPT Codes Codes	Description
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	Breast reduction
19325	Breast augmentation with implant
19328	Removal of intact breast implant
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19355*	Correction of inverted nipples
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19361	Breast reconstruction; with latissimus dorsi flap
19364	Breast reconstruction; with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap
19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)

CPT Codes Codes	Description
19369	Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19380	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
19396	Preparation of moulage for custom breast implant
19499	Unlisted procedure, breast
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
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
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I
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 (eg,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 (eg, fibrous dysplasia), extracranial
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg,

CPT Codes Codes	Description
	fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, 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 (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm
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)
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) (eg, 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
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
21270	Malar augmentation, prosthetic material
21275	Secondary revision of orbitocraniofacial reconstruction
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach
21296	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach
61550	Craniectomy for craniosynostosis; single cranial suture
61552	Craniectomy for craniosynostosis; multiple cranial sutures
61556	Craniotomy for craniosynostosis; frontal or parietal bone flap
61557	Craniotomy for craniosynostosis; bifrontal bone flap

CPT Codes Codes	Description
61558	Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); not requiring bone grafts
61559	Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); recontouring with multiple osteotomies and bone autografts (e.g., barrel-stave procedure) (includes obtaining grafts)

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	Revision Date	Approval Date
Converted corporate to local policy.	02/2021	
Annual review. Reviewed and updated references. CPT code description revised in 2021: 19318, 19325, 19328, 19340, 19342, 19357, 19361, 19364, 19367, 19368, 19369, 19370, 19371, and 19380. CPT 19324 and 19366 deleted in 2021. Clarified in I.A.1. failure of conservative therapy "(unless conservative therapy is not standard of care for the condition, or is contraindicated)." Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." Added the following codes from the retired Craniofacial Surgery policy; 21120, 21121, 21122, 21123, 21137, 21138, 21139, 21159, 21160, 21172, 21175, 21179, 21180, 21181, 21182, 21183, 21184, 21230, 21235, 21255, 21256, 21260, 21261, 21263, 21267, 21268, 21270, 21275, 21280, 21282, 21295, 21296, and craniectomy/craniotomy codes for craniosynostosis. Removed section II as it is included in LA.CP.MP.51 (section III). Clarified in I.A.4.a. "Post-mastectomy,* medically necessary lumpectomy, or other medically necessary breast surgery." Updated II.R. "Mastopexy (except for breast reconstruction post-mastectomy, medically necessary lumpectomy, other medically necessary breast surgery resulting in significant asymmetry). In II.E., changed "InterQual" to "Decision Support Criteria." Added II.U. "Breast reconstruction for fibroadenomas or other benign lesions, unless medically necessary per clinical decision support criteria" to not medically necessary procedures. Added codes 19330 and 19499. Annual review. References reviewed, updated, and reformatted.	04/2021	4/10/2022

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Added to I.A.4.b. "poly-L-lactic acid" and "calcium hydroxylapatite microspheres". Minor rewording with no clinical significance. References reviewed and updated. Reviewed by external specialist. Changed members to members/enrollees.	12/22	2/28/23
Combine payment policy and clinical policy. Added section I. 6. For medically necessary removal of breast implants. Removed "Revision, removal, or replacement of breast implants previously placed for cosmetic reasons" from section II. Added section II. V. for reduction mammoplasty removal of breast implants. Added section III. Reimbursement.	2/23	4/18/23
Annual review. Minor edits to I.A.4.b with no clinical significance. Removed CPT code 11310. References reviewed and updated. Reviewed by internal specialist.	11/23	1/23/24

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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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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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