Policy Number: MP.079.MPC
Last Review Date: 02/18/2025
Effective Date: 03/01/2025

# MP.079 Cosmetic versus Reconstructive Services

Maryland Physicians Care considers **Reconstructive Services** medically necessary for either of the following:

1. When the procedure is intended to primarily improve, restore, or maintain bodily function as a result of an infection or disease;

   OR

2. The procedure is intended to correct a congenital disease or anomaly 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

**Limitations**

1. 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.

2. 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.

3. 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 Maryland Physicians Care 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”.

4. The following cosmetic procedures are excluded from coverage:
   a. Pharmacological regimens, nutritional procedures or treatments
   b. Scar or tattoo removal or revision procedures (such as salabrasion chemosurgery and other such skin abrasion procedures) for the improvement of appearance
   c. Skin abrasion procedures performed as a treatment for acne
   d. 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.
   e. Treatment for skin wrinkles or any treatment to improve the appearance of the skin
   f. Treatment for spider veins
   g. Sclerotherapy treatment of veins
   h. Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a physician for the treatment of gender dysphoria.
   i. Breast Reduction or Breast Lifts as a treatment to psychosocial complaints, psychological symptomatology or for the sole purpose of improving appearance
   j. 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

**<u>Coverage for Panniculectomy, Abdominoplasty, Lipectomy and Liposuction</u>**

**A. Panniculectomy and Abdominoplasty:**

1. Considered medically necessary when the following criteria is met:
   **a.** 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**
   b. Medical records (including consultations or any other pertinent information) document ONE or more of the following:
      i. Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment; **or**

ii. 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, 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**

iii. difficulty ambulating, limitations in physical activity and interference with daily living activities; **or**

iv. **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**

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

d. 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:*

*i. Reaches a body mass index (BMI) less than or equal to 30 kg/m$^2$; **or***

*ii. Has documented at least a 100-pound weight loss; **or***

*iii. 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**

e. 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.

f. 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.

2. Panniculectomy is considered medically necessary as an adjunct to a medically necessary surgery when needed for exposure in extraordinary circumstances.

3. Panniculectomy is considered not medically necessary for ANY other indication.

4. Abdominoplasty is considered cosmetic and not medically necessary for any indication.

**B. Coverage for Lipectomy and Liposuction**

A. Considered medically necessary when the following criteria are met:
   1. When performed in the treatment of lymphedema (i.e., related to surgical mastectomy); or
   2. There is significant functional impairment or medical complication (i.e., difficulty ambulating or performing daily functions); AND
   3. Procedure is expected to improve functional impairment (i.e., volume reduction resulting in significant mobility improvement); AND
   4. 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
   5. Treatment plan requires patient to wear compression garments as instructed and continue postoperative treatment to maintain benefit.

B. Considered cosmetic and not medically necessary when:
   1. Performed in the absence of a significant functional impairment; or
   2. When medically necessary criteria in Section A above is not met

C. Suction-assisted lipectomy used in conjunction with a panniculectomy is considered integral to the primary procedure and will not be separately reimbursed.

**Coverage for Brachioplasty (arm lift), Buttock and Thigh Lift**

1. Considered medically necessary when:
   a. Performed due to significant functional impairment (i.e., excessive skin that interferes with daily living or causes persistent cellulitis, dermatitis or skin ulcerations); or
   b. Impairment persists despite appropriate treatment; or
   c. Procedure is expected to improve functional impairment.

2. Considered cosmetic and not medically necessary when:
    a. Performed in the absence of a significant functional impairment; or
    b. When procedure will not improve a significant functional impairment

**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 a procedure or surgery (surgical and nonsurgical) that reshape normal structures of the body in order 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 Prior Authorization (PA), Medical Payment (MP) or Pharmacy (RX.PA) policy which governs the particular procedure or service**.**

**Applicable Codes**
*The following list of procedure codes may not be all inclusive. Listing of a code in this policy does not imply that the service is a covered/non-covered health service. Benefit coverage is determined by the member's benefit plan document in effect at the time of service and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Maryland Physicians Care Policies and Guidelines may apply.*

| ***The following codes are considered cosmetic and are not covered:*** | |
|---|---|
| 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) |
| 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 |
| 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 |
| 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) |
| 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 |
| 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 |
| 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 |
| 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 |

**References**

1. American Society for Aesthetic Plastic Surgery (ASAPS). Cosmetic Procedures: Choose a Procedure. ©2009-2024, ASAPS. http://www.surgery.org/consumers/procedures
2. American Society of Plastic Surgeons (ASPS): Cosmetic Procedures. © 2023 ASPS. http://www.plasticsurgery.org/cosmetic-procedures.html
3. American Society of Plastic Surgeons (ASPS): Reconstructive Procedures. © 2024 ASPS. http://www.plasticsurgery.org/reconstructive-procedures.html
4. Centers for Medicare and Medicaid Services (CMS). Local Coverage Determinations (LCD) No. L34938- Removal of Benign or Premalignant Skin Lesions. (Contractor: Novitas Solutions, Inc.) Revision Effective Date: 09/26/2019. https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34938&ver=68&Date=&DocID=L34938&bc=iAAAABAAAAAA&
5. Centers for Medicare and Medicaid Services (CMS). Local Coverage Determinations (LCD) No. L39051 – Cosmetic and Reconstructive Surgery. Revision Effective Date: 10/13/2024. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39051&ver=10&bc=0
6. CMS Medicare Home Health Agency Manual: Section 232.11 Cosmetic Surgery, Transmittal 301. Date: June 6, 2002. http://www.cms.hhs.gov/transmittals/downloads/R301HHA.pdf

7. The American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS). Facial Plastic Surgery: Procedures Types. ©2017 AAFPRS. Accessed: January 2020. https://www.aafprs.org/AAFPRS/Procedures/Home.aspx
8. Carl HM, Walia G, Bello R, Clarke-Pearson E, Hassanein AH, Cho B, Pedreira R, Sacks JM. Systematic Review of the Surgical Treatment of Extremity Lymphedema. J Reconstr Microsurg. 2017 Jul;33(6):412-425. Doi: 10.1055/s-0037-1599100. Epub 2017 Feb 24. PMID: 28235214. https://pubmed.ncbi.nlm.nih.gov/28235214/
9. Boyages J, Kastanias K, Koelmeyer LA, Winch CJ, Lam TC, Sherman KA, Munnoch DA, Brorson H, Ngo QD, Heydon-White A, Magnussen JS, Mackie H. Liposuction for Advanced Lymphedema: A Multidisciplinary Approach for Complete Reduction of Arm and Leg Swelling. Ann Surg Oncol. 2015 Dec;22 Suppl 3:S1263-70. doi: 10.1245/s10434-015-4700-3. Epub 2015 Jun 30. PMID: 26122375; PMCID: PMC4686553. https://pubmed.ncbi.nlm.nih.gov/26122375/
10. Freeman, M. (2023). The differences between plastic surgery and cosmetic surgery and why board certification matters. Dated: March 3, 2023. https://www.plasticsurgery.org/news/articles/the-differences-between-plastic-surgery-and-cosmetic-surgery-and-why-board-certification-matters
11. American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria. https://www.plasticsurgery.org/for-medical-professionals/health-policy/recommended-insurance-coverage-criteria

**Disclaimer**

Maryland Physicians Care medical payment and prior authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. The policies constitute only the reimbursement and coverage guidelines of Maryland Physicians Care and its affiliated managed care entities. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies.

Maryland Physicians Care reserves the right to review and update the medical payment and prior authorization guidelines in its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.

## Attachment A

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 PA, MP, or RX.PA Policy in Column III.

This list should not be considered 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 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)<br>17340 Cryotherapy (CO2 slush, liquid N2) for acne<br>17360 Chemical exfoliation for acne (e.g., acne paste, acid) | 17340, 17360 covered with pre-authorization |
| Actinic keratosis, destruction, unless suspicious of malignancy | Informational only<br>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 NOT covered | Exception for Coverage |
|---|---|---|
| Arm, forearm, hand lift (**SEE**: Lipectomy) | | |
| Birthmark/ blemish treatment (**SEE**: Skin lesions, excision of benign) | | |
| Blepharoplasty lower lid | 15820 Blephroplasty, lower eyelid lid<br>15821 Blephroplasty, 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 | | Pre-authorization is required for:<br><br>OnabotulinumtoxinA (Botox®), AbobotulinumtoxinA (Dysport™), RimabotulinumtoxinB (Myobloc®), and IncobotulinumtoxinA (Xeomin®) |
| Breast asymmetry, correction of. *Except in the case of breast cancer* | | **SEE**: **MP.046** - Breast Reconstruction |

| Procedure | Codes for Procedures in Column NOT covered | Exception for Coverage |
|---|---|---|
| Breast reconstruction. *Except in the case of breast cancer* | | **SEE**: **MP.046** - Breast Reconstruction |
| Breast augmentation/lift/implants. *Except in the case of breast cancer* | | **SEE**: **MP.046** Breast Reconstruction |
| Breast reduction | | |
| Breast repositioning | | **SEE: MP.046** Breast Reconstruction |
| Brow lift/ptosis repair | | |
| Buttock lift (**SEE**: Lipectomy) | | |
| Cheek implant (SEE: Malar (facial) implants) | | |
| Chemical peel | 15788 Chemical peel, facial; epidermal<br>15789 Chemical peel, facial; dermal<br>15792 Chemical peel, nonfacial; epidermal<br>15793 Chemical peel, nonfacial; dermal | 15789, 15792, 15793 covered with prior authorization. |
| 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 |

| Procedure | Codes for Procedures in Column NOT covered | Exception for Coverage |
|---|---|---|
| | | score of 3.25 or higher on Computed Tomography (CT) scan.<br><br>Treatment for pectus carinatum is considered medically necessary when member has symptoms indicating medical necessity for 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) | | |
| Collagen replacement therapy: injections or implants | 11950 Subcutaneous injection of filling material (e.g. collagen): 1cc or less<br>11951 1.5 to 5 cc<br>11952 5.1 to 10 cc<br>11954 10 cc or more | |
| Comedone acne extraction (**SEE:** Acne) | | |
| Congenital abnormalities without functional impairment | No specific code for this | |
| Dental congenital abnormalities | No specific code for this | |

| Procedure | Codes for Procedures in Column NOT covered | Exception for Coverage |
|---|---|---|
| Dermoid cyst (when not medically necessary) | 30124 Excision of dermoid cyst, nose: simple, skin, subcutaneous | Covered. Pre-authorization required for non-participating providers only. |
| Dermabrasion | 15780 Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)<br>15781 Dermabrasion; segmental, face<br>15782 Dermabrasion; regional, other than face<br>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<br>Q2026 Injection, Radiesse<br>11950 Subcutaneous injection of filling material (e.g., collagen); 1 cc or less<br>11951 Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc<br>11952 Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc<br>11954 Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc | G0429 & Q2026 covered with pre-authorization |
| Dermoscopy | No specific code for this | |

| Procedure | Codes for Procedures in Column NOT covered | Exception for Coverage |
|---|---|---|
| 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 (**SEE:** Lipectomy) | | |
| Excision/surgical planing of skin of nose for rhinophyma (**SEE:** Rhinophyma) | | |
| 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 | | |

| Procedure | Codes for Procedures in Column NOT covered | Exception for Coverage |
|---|---|---|
| Forehead lift<br>(**SEE**: Rhytidectomy) | | |
| Frown Line reduction<br>(Refer to Glabella) | | |
| Genioplasty<br>(**SEE**: Rhytidectomy and Lipectomy) | 21120 Genioplasty: augmentation (autograft, allograft, augmentation) | Covered with pre-authorization |
| Glabella/Glabelloplasty (frown lines), excision/correction<br>(**SEE**: Rhytidectomy) | 21137 Reduction forehead; contouring only<br>21138 Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)<br>21139 Reduction forehead; contouring and setback of anterior frontal sinus wall | Covered with pre-authorization |
| 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<br>15776 Punch graft for hair transplant; more than 15 punch grafts | |
| | | |

| Procedure | Codes for Procedures in Column NOT covered | Exception for Coverage |
|---|---|---|
| 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 | Covered with pre-authorization |
| Hip Lift (**SEE**: Lipectomy) | | |
| Hyperhidrosis surgery including endoscopic transthoracic sympathecotomy (ETS), sympathectomy (radial artery, ulnar nerve, superficial palmar arch), video assisted thoracic sympathectomy (VATS) | | **SEE: MP.036** - Iontophoresis |
| Injectable fillers (**SEE**: Dermal fillers) | | |
| Insertion or injection of prosthetic material to replace absent adipose tissue. *Except for breast cancer* | | **SEE: MP.046** - Breast Reconstruction |
| 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 | |

| Procedure | Codes for Procedures in Column NOT covered | Exception for Coverage |
|---|---|---|
| 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<br>15833 Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg<br>15834 Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip<br>15835 Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock<br>15836 Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm<br>15837 Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand<br>15838 Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad<br>15839 Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area | 15832 through 15839 covered with pre-authorization. |

| Procedure | Codes for Procedures in Column NOT covered | Exception for Coverage |
|---|---|---|
| Liposuction unless an integral part of another covered procedure | 15876 Suction assisted lipectomy; head and neck<br>15877 Suction assisted lipectomy; trunk<br>15878 Suction assisted lipectomy; upper extremity<br>15879 Suction assisted lipectomy; lower extremity | |
| Malar (facial) implants | No specific code for this | |
| Mastopexy (breast lift for pendulous breasts) | | **SEE: MP.046** - Breast Reconstruction |
| 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) | | |
| Moon face correction (as a result of corticosteroid therapy) | No specific code for this | |
| Nasal septum cartilage graft | 20912 Cartilage graft, nasal septum | Covered with pre-authorization. |
| Obesity surgery | | **SEE: PA.040** Bariatric Procedures |

| Procedure | Codes for Procedures in Column NOT covered | Exception for Coverage |
|---|---|---|
| Otoplasty | 69300 Otoplasty, protruding ear, with or without size reduction | Covered with pre-authorization |
| 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 | |
| Rhinoplasty | 30400 Rhinoplasty; primary; lateral & alar cartilages and/or elevation of nasal tip<br>30410 Rhinoplasty; complete; external parts including bony pyramid; lateral & alar cartilages &/or elevation of nasal tip.<br>30450 Rhinoplasty, secondary, major revision | **SEE: MP.038** - Septoplasty/Rhinoplasty<br><br>Pre-auth required for non-participating providers only. |
| Refractive keratoplasty/eye surgery (LASIK, PTK) | 65760 Keritomileusis (LASIK)<br>65765 Keratophakia<br>65767 Epikeritoplasty | Covered with pre-authorization |

| Procedure | Codes for Procedures in Column NOT covered | Exception for Coverage |
|---|---|---|
| Rhinophyma treatment/excision | 30120 Excision or surgical planing of skin of nose for rhinophyma | Covered. Pre-authorization required for non-participating providers only. |
| Removal of unwanted/excessive hair growth (**SEE:** Hair Removal) | | |
| Rhytidectomy (face, chin, neck, browlift) | 15824 Rhytidectomy; forehead<br>15825 Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)<br>15826 Rhytidectomy; glabellar frown lines<br>15828 Rhytidectomy; cheek, chin, and neck<br>15829 Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap | |
| Rosacea, treatment of (including erythema, telangiectasia)<br>*Except when atypical or causing functional limitation* | Codes are the same as Hemangioma | |
| Salabrasion (tattoo removal) (**SEE:** Tattoo) | | |
| Scar revision<br>*Except when atypical or causing functional limitation (i.e. affects vision, breathing, hearing, ability to eat,* | 15786 Abrasion; single lesion (e.g., keratosis, scar)<br>15787 Abrasion; each additional four lesions or less | Burn scars in children when medically necessary |

| Procedure | Codes for Procedures in Column NOT covered | Exception for Coverage |
|---|---|---|
| *bleeding, ulceration, and/or infection.* | | |
| Sclerosing of Spider Veins (**SEE:** Spider vein removal/repair) | | |
| Septoplasty | | **SEE: MP.038** – Septoplasty/Rhinoplasty |
| Septorhinoplasty | | **SEE: MP.038** - Septoplasty-Rhinoplasty |
| 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-cancerous or cancerous lesions.* | Informational only<br>No codes for configuration because of potential medical necessity | |
| Skin removal for excessive/redundant skin. *Except for breast cancer* (**SEE:** Lipectomy) | | **SEE: MP.046** - Breast Reconstruction |
| Skin rejuvenation and resurfacing (**SEE:** Dermabrasion) | No specific code for this | |

| Procedure | Codes for Procedures in Column NOT covered | Exception for Coverage |
|---|---|---|
| | | |
| Spider vein removal/repair, including telangiectasia and stellate angioma | 36468 Single or multiple injections of sclerosing solutions, spider veins (telangiectasia), limb or trunk | Covered with pre-authorization. |
| 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) | | Hyaluronic Acid Products |
| Surgical repair of inverted nipple | | **SEE: MP.046** - Breast Reconstruction |
| Tattoo (decorative or self induced) removal/treatment | No specific code for this | **SEE: MP.046** - Breast Reconstruction |
| Thigh lift (**SEE**: Lipectomy) | | |
| Temporal Mandibular Joint (TMJ), non surgical treatment | | **SEE: MP.016** - TMJ |
| Tissue expansion, when not medically necessary | | **SEE: MP.046** - Breast Reconstruction |

| Procedure | Codes for Procedures in Column NOT covered | Exception for Coverage |
|---|---|---|
| Torn earlobe repair | No specific code for this | |
| Umbilectomy, omphalectomy, excision of umbilicus (separate procedure) | 49250 Umbilectomy, omphalectomy, excision of umbilicus | Covered with pre-authorization. |
| Varicose veins, removal of spider veins (telangiectasia) | | |
| Voice lifting procedures (To restore voice to youthful quality, implants, injections of fat or collagen) | | **SEE MP.112 –** Laryngeal Inj for Vocal Cord Augmentation |
| XEOMIN® (incobotulinumtoxinA) injections when used to improve the appearance of glabellar lines | | OnabotulinumtoxinA (Botox®), AbobotulinumtoxinA (Dysport™), RimabotulinumtoxinB (Myobloc®), and IncobotulinumtoxinA (Xeomin®) |