PolicyStat ID 13820813

Last Approved	6/13/2023
Effective	7/24/2023
Next Review	6/12/2024
Area	Medical Policy
Lines Of Business	All Lines of Business

Cosmetic Procedures

PURPOSE:

This policy discusses procedures and services that are generally considered cosmetic in nature.

DEFINITIONS:

Cosmetic Surgery: Procedures or services that change or improve appearance without significantly improving physiological function.

Plastic Surgery: A surgical procedure dedicated to reconstruction of facial and body defects due to birth disorders, trauma, burns, and disease. Plastic surgery is intended to correct dysfunctional areas of the body and is reconstructive in nature.

PROCEDURE:

1. The following procedures are considered cosmetic nature, and therefore not medically necessary (not intended to be an all-inclusive list):
    - Abdominoplasty
    - Blepharoplasty
    - Blepharoptosis repair
    - Body contouring
    - Brow lift
    - Breast lift and implants for non-reconstructive purposes
    - Calf implants
    - Canthopexy
    - Cheek/malar implants
    - Chemical peels (actinic keratosis is excluded, see related policy for additional

information)

- Chin or nose implants
- Collagen and/or filler injections
- Cool sculpting
- Construction of clitoral hood
- Dermabrasion
- Face or forehead lifts
- Facial bone reduction
- Facial feminization or masculinization surgery
- Feminization of torso
- Jaw reduction or contouring
- Hair removal and electrolysis
- Hair transplantation or implantation
- Lipectomy
- Lip enhancements
- Lip reduction
- Masculinization of torso
- Mastopexy
- Neck tightening
- Nipple reconstruction
- Nose implants
- Otoplasty
- Panniculectomy
- Pectoral implants
- Pitch-raising surgery
- Removal of redundant skin (unless there is a functional impairment)
- Removal of benign skin lesions
- Rhinoplasty
- Scar removal
- Skin resurfacing
- Skin tag removal
- Tattoo removal
- Tracheal shave
- Vaginal rejuvenation procedures

- Voice modification

2. However, any of the above procedures may be considered medically necessary, and reconstructive in nature, when the following criteria are met:
    - There is a documented physical and/or physiological abnormality that causes a functional impairment resulting in deviation from normal function of a tissue, or organ; AND
    - The abnormality results in significantly impaired and/or limited capacity to perform physical and motor tasks, independent movement, and perform basic life functions; AND
    - The abnormality is a result of a medical condition, accidental injury, or congenital defect; AND
    - The proposed procedure can reasonably be expected to restore physiological functions.

Note: This policy is not applicable to breast reconstruction following surgical interventions for oncologic indications including but not limited to implants, expanders, and nipple tattooing.

Note: The Health Plan complies with all Medicare National Coverage Determinations (NCDs) and applicable Local Coverage Determinations (LCDs) for all therapies, items, services, and/or procedures that are covered benefits under Medicare. If the coverage criteria in this policy conflicts with any NCDs or relevant LCD, the relevant document controls the application of services regardless of the version of the NCD or LCD listed in the reference section.

Please review the following policies for additional criteria and exceptions:

- Gender Affirmation
- Actinic Keratosis

CODING:

CPT Code	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)
11400-11446	Excision, benign lesion including margins, except skin tag (unless listed elsewhere)
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)
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, non-facial; epidermal
15793	Chemical peel, non-facial; dermal
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead

CPT Code	Description
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
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
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
17360	Chemical exfoliation for acne (e.g., acne paste, acid)
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19316	Mastopexy
19325	Breast augmentation with implant
21089	Unlisted maxillofacial prosthetic procedure
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
21299	Unlisted craniofacial and maxillofacial procedure
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)

CPT Code	Description
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
56620	Vulvectomy simple; partial
58999	Unlisted procedure, female genital system (nonobstetrical)(vaginal rejuvenation)
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
67909	Reduction of overcorrection of ptosis
69300	Otoplasty, protruding ear, with or without size reduction
L8600	Implantable breast prosthesis, silicone or equal - Add to CPT Tool(not currently in CPT tool) and auth list.

REFERENCES:

American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Abdominoplasty. July 2006, Coding Updated January 2016. Reaffirmed September 26, 2018. Accessed December 10, 2021.

American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Nasal Surgery. July 2006, Revised May 2021. Accessed December 10, 2021.

American Academy of Cosmetic Surgery. Frequently Asked Questions About Cosmetic Surgery. Accessed December 10, 2021. https://www.cosmeticsurgery.org/page/CosmeticSurgery .

Palmetto GBA. Local Coverage Determination: Cosmetic and Reconstructive Surgery. LCD L33428. Original Effective Date October 1, 2015. Revision Effective Date July 29, 2021. Accessed December 15, 2021.

Palmetto GBA. Local Coverage Article: Cosmetic and Reconstructive Surgery. LCA 56658. Original Effective Date July 4, 2019. Revision Effective Date January 1, 2023. Accessed May 3, 2023.

American College of Obstetricians and Gynecologists (ACOG). Vaginal 'rejuvenation' and cosmetic

vaginal procedures. ACOG Committee Opinion No. 795. January 2020. Accessed January 4, 2022.

Bowyer L, Krebs G, Mataix-Cols D, Veale D, Monzani B. A critical review of cosmetic treatment outcomes in body dysmorphic disorder. *Body Image*. 2016;19:1-8. doi:10.1016/j.bodyim.2016.07.001. Accessed January 4, 2022.

Atiyeh B, Costagliola M, Illouz YG, Dibo S, Zgheib E, Rampillon F. Functional and Therapeutic Indications of Liposuction: Personal Experience and Review of the Literature. *Ann Plast Surg*. 2015;75(2):231-245. doi:10.1097/SAP.0000000000000055. Accessed January 5, 2022.

Toma T, Harling L, Athanasiou T, Darzi A, Ashrafian H. Does Body Contouring After Bariatric Weight Loss Enhance Quality of Life? A Systematic Review of QOL Studies. *Obes Surg*. 2018;28(10):3333-3341. doi:10.1007/s11695-018-3323-8. Accessed January 5, 2022.

Cohen JL, Dayan SH, Brandt FS, et al. Systematic review of clinical trials of small- and large-gel-particle hyaluronic acid injectable fillers for aesthetic soft tissue augmentation. *Dermatol Surg*. 2013;39(2):205-231. doi:10.1111/dsu.12036. Accessed January 5, 2022.

Levy LL, Emer JJ. Complications of minimally invasive cosmetic procedures: prevention and management. *J Cutan Aesthet Surg*. 2012;5(2):121-132. doi:10.4103/0974-2077.99451. Accessed January 5, 2022.

U.S. Food and Drug Administration (FDA). Statement from FDA Commissioner Scott Gottlieb, M.D., on efforts to safeguard women's health from deceptive health claims and significant risks related to devices marketed for use in medical procedures for "vaginal rejuvenation". FDA Statement. July 30, 2018, updated August 2, 2018. Accessed January 5, 2022. https://www.fda.gov/news-events/press-announcements/statement-fda-commissioner-scott-gottlieb-md-efforts-safeguard-womens-health-deceptive-health-claims

Centers for Medicare & Medicaid Services(CMS). National coverage determination (NCD) for plastic surgery to correct "Moon Face" (140.4). May 1, 1989. Accessed January 5, 2022.

CGS Administrators, LLC. Local Coverage Determination: Blepharoplasty. LCD L33944. Effective October 1, 2015, revision effective October 27, 2022. Accessed May 4, 2023.

CGS Administrators, LLC. Local Coverage Article: Blepharoplasty. LCA A56439. Effective October 1, 2015, revision effective October 27, 2022. Accessed May 4, 2023.

Labib AM, Patel BC, Milroy C. Blepharoplasty, Lower Lid, Canthal Support. [Updated 2022 Aug 29]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing. Accessed May 4, 2023.

Caterson SA, Singh M, Orgill D, et al. Development of Standardized Clinical Assessment and Management Plans (SCAMPs) in Plastic and Reconstructive Surgery [published correction appears in Plast Reconstr Surg Glob Open. 2016 Jul;4(7):e510]. *Plast Reconstr Surg Glob Open*. 2015;3(9):e510. Published 2015 Sep 9. doi:10.1097/GOX.0000000000000504. Accessed May 4, 2023.

American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Blepharoplasty. Approved in July 2008, re-approved in December 2020. Accessed May 4, 2023.

American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Panniculectomy. Approved July 2006, re-approved in March 2019. Accessed May 4, 2023.

American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Skin Lesions. 2003. Accessed May 5, 2023.

Nazarian R, Eshraghi AA. Otoplasty for the protruded ear. *Semin Plast Surg*. 2011;25(4):288-294. doi:10.1055/s-0031-1288921. Accessed May 5, 2023.

POLICY HISTORY:

Date	Description of Changes
7/29/2022	Added criteria to include the following: Chemical peels (actinic keratosis is excluded, see related policy for additional information). Added Actinic Keratosis to related policies. Added CPT code 17360.
5/24/2023	Annual Review: Added panniculectomy, blepharoptosis repair, canthopexy, hair implantation, otoplasty, breast implant for non-reconstructive purposes. Added CPT/HCPCS codes: 15876, 15877, 15878, 15879, 17380, 19325, 21089, 21280, 21282, 21299, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 69300 L8600. Added/updated references. Corrected typos.

POST-PAYMENT AUDIT STATEMENT:

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by THP at any time pursuant to the terms of your provider agreement.

DISCLAIMER:

This policy is intended to serve as a guideline only and does not constitute medical advice, any guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. This policy is intended to address medical necessity guidelines that are suitable for most individuals. Each individual's unique clinical situation may warrant individual consideration based on medical records. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and THP's professional judgment. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification, and utilization management guidelines. Unless otherwise noted within the policy, THP's policies apply to both participating and non-participating providers and facilities. THP reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by THP. THP has full and final discretionary authority for its interpretation and application. Accordingly, THP may use reasonable discretion in interpreting and applying this policy to health care services provided in any particular case.

All Revision Dates

6/13/2023, 9/13/2022, 1/17/2022