Policy Number	**SUR716.001**
Policy Effective Date	**02/15/2025**
Policy End Date	**12/31/2025**

Cosmetic and Reconstructive Procedures

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Related Policies (if applicable)
Multiple: See Coverage

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: For Illinois only: Illinois Public Act 103-0123 (IL HB 1384) Coverage for Reconstructive Services requires the following policies amended, delivered, issued, or renewed on or after January 1, 2025 (Individual and family PPO/HMO/POS; Student; Group [Small Group; Mid-Market; Large Group Fully Insured PPO/HMO/POS] or Medicaid), to provide coverage for medically necessary services that are intended to restore physical appearance on structures of the body damaged by trauma.

EXCEPTION: For HCSC members residing in the state of Arkansas, § 23-79-1502 relating to craniofacial anomaly corrective surgery, requires coverage and benefits for reconstructive surgery and related medical care for a person of any age who is diagnosed as having a craniofacial anomaly if the surgery and treatment are medically necessary to improve a functional impairment that results from the craniofacial anomaly. Coverage shall also be required, annually, for Sclera contact lenses, including coatings, office visits, an ocular impression of each eye, and any additional tests or procedures that are medically necessary for a craniofacial patient. Coverage shall also be required every two [2] years, two [2] hearing aids and two [2] hearing aid molds for each ear; this includes behind the ear, in the ear, wearable bone conductions, surgically implanted bone conduction services, and cochlear implants. Medical care coverage required includes coverage for reconstructive surgery, dental care, and vision care. This applies to the following: Fully Insured Group, Student, Small Group, Mid-Market, Large Group,

HMO, EPO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

EXCEPTION: For HCSC members residing in the state of Arkansas, § 23-79-150 relating to musculoskeletal disorders of the face, neck, or head, requires coverage, when such coverage is elected by the group policyholder, for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and nonsurgical procedures. This coverage shall be provided for medically necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. This applies to the following: Fully Insured Group, Student, Small Group, Mid-Market, Large Group, HMO, EPO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

EXCEPTION: For HCSC members residing in the state of Arkansas, § 23-99-405 related to coverage of mastectomy and reconstruction services, should an enrollee elect reconstruction after a mastectomy, requires coverage for surgery and reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and protheses and coverage for physical complications at all stages of a mastectomy, including lymphedema. This applies to the following: Fully Insured Group, Student, Small Group, Mid-Market, Large Group, HMO, EPO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

EXCEPTION: For HCSC members residing in the state of Mississippi, §83-9-45 requires coverage for diagnostic and surgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage for diagnostic services and surgery shall be the same as that for treatment to any other joint in the body and shall apply if the treatment is administered or prescribed by a physician or dentist. This applies to the following: Fully Insured Group, Small Group, Mid-Market, Large Group, HMO, EPO, PPO, POS.

Coverage

This medical policy does NOT address Gender Reassignment Services (Transgender Services). This medical policy IS NOT TO BE USED for Gender Reassignment Services. Refer to SUR717.001, Gender Assignment Surgery and Gender Reassignment Surgery with Related Services

NOTE 1: For coverage of specific procedures please see the specific medical policy where indicated.

NOTE 2: Determinations of whether a proposed therapy would be considered reconstructive or cosmetic should always be interpreted in the context of the specific contract benefits language. In general, the presence of a functional impairment would render its treatment medically necessary and thus not subject to contractual definitions of reconstructive or cosmetic.

COSMETIC PROCEDURES:

Services that are provided primarily to alter and/or enhance appearance in the absence of documented impairment of physical function **are considered to be cosmetic**.

The majority of contracts have exclusions for cosmetic services or supplies. The following table below indicates services that may be considered either cosmetic or reconstructive, depending on the diagnosis, and documentation of progressive functional impairment. This list is not intended to be all inclusive. Refer to the individual medical policy if indicated for a specific procedure.

Cosmetic procedures **would not be eligible for benefits** because of psychiatric, psychosocial or emotional issues.

Special Comment Regarding Cosmetic Services: Determination of benefit coverage for procedures considered to be cosmetic is based on how a member's contract defines cosmetic services and their eligibility for benefit coverage.

RECONSTRUCTIVE PROCEDURES:

Procedures are considered reconstructive and therefore **may be considered medically necessary when**:

- There is documented evidence of physical functional impairment; OR
- Services are provided primarily to correct documented progressive impairment of physical function that interferes with the performance of activities of daily living; OR
- The conditions of impairment must meet the definition of reconstructive services in the benefit contract of the member for whom a procedure is being considered.

Documentation for reconstructive surgery must include appropriate historical medical record documentation which may include any of the following:

- Photographs; and/or
- Consultation reports; and/or
- Operative reports and/or other applicable hospital records (examples: pathology report, history and physical); and/or
- Office records; and/or
- Letters with pertinent information from:
  1. Providers;
  2. Subscribers.

The plan requires medical records for determination of medical necessity. When medical records are requested, a letter of support and/or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination.

Table 1: The following table contains a listing of cosmetic and reconstructive procedures, which include but are not limited to the following:

Clinical Conditions	Reconstructive	Cosmetic

Abdominoplasty	Cosmetic for all indications.	Cosmetic for all indications.
Cool sculpting (may also be known as cryolipolysis or fat freezing).	Experimental, investigational, and/or unproven for all indications.	Experimental, investigational, and/or unproven for all indications.
Congenital Anomaly.	Correction of a condition existing at birth, which is a significant deviation from common anatomical form.	CHECK CONTRACTS FOR COVERAGE ELIGIBILITY.
Gingivoplasty.	In conjunction with cleft lip and palate surgery.	When performed to improve appearance and not associated with correction of congenital anomaly. (See information under Congenital Anomaly).
Hair Transplant (Hairplasty).	For permanent alopecia as a result of trauma.	For male pattern alopecia. For alopecia due to disease or therapeutic procedures. CHECK CONTRACTS FOR COVERAGE ELIGIBILITY.
Injectable Implant/Injectable Dermal Fillers.	Laryngeal Augmentation System, or Laryngeal Augmentation Implant for indications of vocal fold medialization and vocal fold insufficiency in accordance with FDA labeling (e.g., Radiesse® Laryngeal Implant; Juliesse™ Laryngeal Implant). Injectable dermal fillers (e.g., Radiesse®, Sculptra®) used to sculpt or smooth body and/or facial contours in cases of human immunodeficiency virus (HIV)-associated lipodystrophy in the presence of a functional impairment.	Injectable dermal fillers used to sculpt or smooth body and/or facial contours (e.g., Radiesse®, Sculptra®) for all other indications.
Keloid removal.	When the following conditions exist: • Ulceration or infection with or without sinus tracts;	Removal of small keloid which does not interfere with normal function.

	• Extremely large, painful keloid associated with stretching; • Rapid growth of the keloid interferes with normal function.	
Mentoplasty, Genioplasty or chin implant.	Cosmetic for all indications. See Medical Policy SUR717.001 Gender Assignment Surgery and Gender Reassignment Surgery with Related Services.	Cosmetic for all indications. See also Medical Policy SUR717.001 Gender Assignment Surgery and Gender Reassignment Surgery with Related Services.
Mesotherapy-Injection for Lipolysis.	Cosmetic for all indications.	Cosmetic for all indications.
Neurofibromas, cutaneous destruction.	When the following conditions exist that may interfere with normal function such as: Symptomatic neurofibromas (painful, tender, infected).	Destruction of cutaneous neurofibromas that do not interfere with normal function.
Otoplasty.	• Ears are absent; or • Deformed from trauma, neoplastic surgery, disease or congenital anomalies. (See information under Congenital Anomaly).	To correct large or protruding ears.
Panniculectomy.	When the following conditions are met: • Panniculus hangs below the level of the pubis; documented by photographs. • Documentation that the panniculus causes chronic intertrigo that consistently reoccurs over a 3-month period while receiving medical treatment or is refractory	Cosmetic for all other indications.

	to appropriate medical treatment that includes oral and/or topically prescribed medication over a 3-month period. • Photographs documenting the presence of intertrigo.	
Rhytec Portrait® Skin Regeneration.	Cosmetic for all indications.	Cosmetic for all indications.
Restoration of body form. Refer to SUR717.001 for Gender Assignment Surgery and Gender Reassignment Surgery with Related Services.	• Following an accidental injury or trauma; • Following a medically necessary mastectomy regardless of when the mastectomy was performed; • Correction of inverted nipples only if a functional impairment is present; • Collagen implantation to restore the natural contour to skin that has been damaged by trauma or congenital anomalies. (See information under Congenital Anomaly); • Cystocele and/or urethrocele repair; • Testicular prostheses after medically necessary orchiectomy for indications including, but not limited to torsion and undescended testicle; • Testicular prosthesis in the case of ambiguous genitalia.	• Body piercing; • Glabellar frown line; • Testicular prosthesis; • Buttock or thigh lift; • Neck tuck; • Hirsutism; • Skin tags; • Papillomas; • Correction of inverted nipples without functional impairment; • Collagen implant as surgery for acne; • Surgery for acne scarring; • Restore the natural contour of skin damaged by age.
Rhytidectomy.	For treatment of burns.	For treatment of the face for aging skin.
Submental fat in adults (i.e., double chin) treated with	Cosmetic for all indications.	Cosmetic for all indications.

Kybella ™ (deoxycholic acid) injections.		
Suction Assisted Lipectomy or body contouring with silicone or liposuction.	Body contouring following surgery is an integral part of the procedure. See Medical Policy SUR716.011 Reconstructive Breast Surgery. See Medical Policy SUR701.024 Surgery for Lipedema and Lymphedema.	Suction assisted lipectomy, by any method. See also Medical Policy SUR716.011 Reconstructive Breast Surgery. See also Medical Policy SUR701.024 Surgery for Lipedema and Lymphedema.
Scar revision.	Resulting from trauma or neoplastic surgery. Documentation must show conservative treatment of the scar has failed.	When performed to improve appearance and not associated with an injury or the result of neoplastic surgery.
Strabismus.	Regardless of: • The age of the patient; • Date of the origin of deviation; • Subsequent surgical corrections.	None
Tattoos.	• Excision/treatment of traumatic or therapeutic tattoos; • For nipple/areola reconstruction following mastectomy.	To correct color defects of the skin.

Table 2: The following table contains a listing of clinical conditions/treatments and/or surgeries with the corresponding Medical Policy that should be referred to for Coverage Information.

Clinical Conditions	See Medical Policy
Acne Scarring.	See Medical Policies: THE801.028 SUR716.018
Breast augmentation with implant.	See Medical Policy SUR716.009
Blepharoplasty.	See Medical Policy SUR716.004
Chemical Peels.	See Medical Policy SUR716.018
Gynecomastia.	See Medical Policy SUR716.017
Mammaplasty & contralateral breast surgery.	See Medical Policy SUR716.011
Mammaplasty, reduction.	See Medical Policy SUR716.012

Mandibular or maxillary resection.	See Medical Policies: SUR705.010 SUR705.030 SUR706.009
Mastectomy.	See Medical Policy SUR716.015
Mastopexy.	See Medical Policy SUR716.010
Nonpharmacologic Treatment of Rosacea.	See Medical Policy THE801.030
Obesity.	See Medical Policy SUR716.003
Photodynamic Therapy (PDT).	See Medical Policy THE801.027
Port Wine Stain.	See Medical Policy SUR704.008
Psoriasis.	See Medical Policy THE801.033
Refractive keratoplasty.	See Medical Policy SUR713.001
Rhinoplasty with or without Septoplasty.	See Medical Policy SUR706.001
Sclerotherapy.	See Medical Policy SUR707.016
Surgical Treatment of Pectus Excavatum and Pectus Carinatum.	See Medical Policy SUR701.044

Policy Guidelines

None.

Description

The coverage of medical and surgical procedures to treat anomalies of the musculoskeletal and of the integumentary systems (i.e., the skin, subcutaneous and accessory structures including the breast) is often based on a determination of whether the anomalies is considered cosmetic or reconstructive in nature.

COSMETIC PROCEDURES are intended solely to improve appearance and self-esteem not to restore bodily function or correct deformity.

RECONSTRUCTIVE SURGERY restores form but does not always correct or restore bodily function. It is generally done to improve function but may also be done to approximate a normal appearance.

Rationale

Determinations of whether a proposed therapy would be considered reconstructive or cosmetic should always be interpreted in the context of the specific benefit language.

The requirement of the presence of a functional impairment for a specific etiology may vary as applied to dermatologic conditions. See the related documents list for individual policies which

supersede generic language describing cosmetic and reconstructive procedures. It should be noted that the presence of a functional impairment would render treatment medically necessary and thus not subject to contractual definitions of reconstructive or cosmetic.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	11200, 11201, 11920, 11921, 11922, 11950, 11951, 11952, 11954, 11960, 11970, 15775, 15776, 15780, 15781, 15782, 15783, 15786, 15787, 15824, 15825, 15826, 15828, 15829, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 15876, 15877, 15878, 15879, 17380, 19318, 19355, 21120, 21121, 21122, 21123, 21282, 31573, 31574, 41872, 54660, 69090, 69300, 0419T, 0420T, 0479T, 0480T
HCPCS Codes	G0429, J3490, L8607, Q2026, Q2028

*Current Procedural Terminology (CPT®) ©2023 American Medical Association: Chicago, IL.

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Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been changed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change
02/15/2025	Document updated with literature review. The following changes were made to the Coverage: “congenital defects” or “congenital abnormalities” were replaced with “congenital anomalies” and added “(See information under Congenital Anomaly) to the following Clinical Conditions addressing Gingivoplasty, Otoplasty, Restoration of body form. No new references added.
02/01/2024	Document updated with literature review. The following changes were made to the Coverage: 1) Added Reconstructive and Cosmetic indications for Gingivoplasty; 2) Replaced the Cosmetic indication of over the age of 19 with CHECK CONTRACTS FOR COVERAGE ELIGIBILITY for Congenital Anomaly. Reference number 13 add, other references updated.
05/01/2023	Document updated with literature review. The following changes were made to the Coverage: 1) Under Otoplasty in the reconstructive column - Added “neoplastic” to the following statement: Deformed from trauma, neoplastic surgery, disease or congenital defects; 2) Under Scar revision in

	the reconstructive column - Added “neoplastic” to the following statement: Resulting from trauma or neoplastic surgery. Documentation must show conservative treatment of the scar has failed; 3) Under Restoration of body form in the reconstructive column - Removed the following statement: Disfiguring or extensive scars resulting from neoplastic surgery. No new references added; some updated, one reference removed.
01/15/2022	Document updated with literature review. The following changes were made to Coverage: Separated abdominoplasty/panniculectomy into two separate coverage statements. Abdominoplasty coverage changed to cosmetic for all indications. Panniculectomy coverage has changed under both the Reconstruction column as well as the Cosmetic column. Removed pectus excavatum and pectus carinatum from this medical policy as it is now addressed on medical policy SUR701.044 Surgical Treatment of Pectus Excavatum and Pectus Carinatum. Reference 13 added; others removed.
08/01/2021	Document updated. The following changes were made to Coverage: 1) Changed position on injectable dermal fillers (e.g. Radiesse®, Sculptra®) from “cosmetic” to “may be considered reconstructive in cases of human immunodeficiency virus (HIV)-associated lipodystrophy in the presence of a functional impairment”; 2) Removed language on EGRIFTA™. Reference 6 removed.
01/15/2021	Document updated with literature review. The following change was made in Coverage: Fractional ablative laser fenestration for functional improvement of scars was removed from Table 1, as experimental, investigational and/or unproven. Added reference 15; others removed.
04/15/2020	Document updated with literature review. The following changes were made: Coverage section was revised and divided into two tables, one table focuses on clinical conditions and addresses Reconstructive and Cosmetic indications. Changes to the table addressing Reconstructive and Cosmetic indications include: 1) Editorial wording changes to Injectable Implant section; 2) the following was removed from Restoration of Body Form: As a general rule restoration should be performed within 2 years of the accident or initial injury. 3) Treatments addressing acne and Rosacea were moved to the second table. The second table notes conditions, treatments and/or surgeries and directs users to specific medical policies that address those topics. 4) Referral to SUR717.001 for Gender Assignment Surgery and Gender Reassignment Surgery with Related Services was added to the Mentoplasty, Genioplasty or chin implant section of the table. 5) Two references removed. Reference 17 added.
03/01/2019	The following changes were made in Coverage: 1) Removed surgical reshaping of the nose for Rhinophyma from the cosmetic table and added refer to medical policy 801.030 For Nonpharmacologic Treatment of Rosacea.

01/01/2018	Document updated with literature review. The following change was made to Coverage: 1) Added "Fractional ablative laser fenestration for functional improvement of scars is considered experimental, investigational, and/or unproven for all indications."
07/01/2017	Document updated with literature review. The following was added to coverage: Cool sculpting (may also be known as cryolipolysis or fat freezing) is considered experimental, investigational, and/or unproven for all indications. The following was removed from the coverage section: Relume™ for treatment of Stretch Marks.
08/15/2016	Document updated with literature review. Coverage under Injectable Implant section, had Juliessa changed to JuliesseTM. Under the Reconstructive section and under the Cosmetic section ProlarynTM gel (formerly known as Radiesse or Juliessa Laryngeal Implant) was removed and replaced by Radiesse.
01/01/2016	The following was added to the Coverage section: Neurofibromas, cutaneous destruction is considered reconstructive when the following conditions exist that may interfere with normal function such as: symptomatic neurofibromas (painful, tender, infected); destruction of cutaneous neurofibromas that do not interfere with normal function are considered cosmetic.
09/15/2015	Medical document updated with literature review. The following was added to the coverage section: Mesotherapy-Injection for Lipolysis, is considered cosmetic for all indications and Submental fat in adult (i.e., double chin) treated with Kybella TM (deoxycholic acid) injections is considered cosmetic for all indications.
08/15/2013	Medical document updated with literature review. The following was added to the "Coverage" section under "Injectable Implant" – "Radiesse Laryngeal Implant for indications of vocal fold medialization and vocal fold insufficiency in accordance with FDA labeling" found under the "Reconstructive" column in the "Clinical Conditions/Reconstructive/Cosmetic" table. The following was removed "This policy is no longer scheduled for routine literature review and update."
01/15/2012	Medical document updated with literature review. The following was added: EGRIFTA is considered cosmetic for all indications, including, but not limited to the reduction of excess abdominal fat in the HIV-infected patients with lipodystrophy.
03/15/2011	Medical document updated. The coverage of Radiesse® was expanded by adding the following: Radiesse is considered cosmetic for all indications, including, but not limited to subdermal implantation for restoration and/or correction of the signs of facial fat loss (lipodystrophy) in people with human immunodeficiency virus.
04/15/2009	Coverage revised to allow testicular prosthesis after orchiectomy for reconstruction after malignancy.

03/15/2008	Revised/updated entire document. This policy is no longer scheduled for routine literature review and update.
02/15/2008	Coverage revised
09/15/2007	Coverage revised
03/15/2007	Revised/updated entire document
10/15/2006	Revised/updated entire document
03/01/2006	Revised/updated entire document
08/01/2005	Revised/updated entire document
11/01/1999	Revised/updated entire document
09/01/1999	Revised/updated entire document
05/01/1996	Revised/updated entire document
07/01/1994	Revised/updated entire document
01/01/1993	Revised/updated entire document
10/01/1992	Revised/updated entire document
05/01/1990	New medical document