

Clinical Policy: Cosmetic and Reconstructive Procedures

Reference Number: MC.CP.MP.31

Date of Last Revision: 12/25

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Description

Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, surgery, infection, tumors or disease.¹

This policy outlines the medical necessity criteria for cosmetic and reconstructive procedures, which is intended to supplement the criteria in the Local Coverage Determinations (LCDs) for cosmetic and reconstructive surgery: L33428, L39506, L38914, L35090, and L39051. The medical necessity criteria in these LCDs note coverage indications related to improving the function of abnormal body structures but do not provide detailed criteria for skin tag removal or scar/keloid revision or removal, limiting the ability to consistently determine medical necessity for reconstructive procedures that may benefit the member/enrollee. This policy criteria is sourced from Medicare Benefit Policy Manuals, LCDs, The Women's Health and Cancer Rights Act (WHCRA), as well as treatment guidelines from the American Society of Plastic Surgeons and FDA approved indications for facial dermal injections.

Benefits of reconstructive surgery performed on abnormal body structures include improvement in function and relief of pain and irritation. Risks of reconstructive surgery include infection, scarring, poor wound healing, bleeding, thrombosis and complications related to anesthesia. For this reason, reconstructive surgery should only be performed when proven safe and effective in order to reduce unnecessary risks.

Note:

- *This policy should only be used if there are no available procedure specific criteria.*
- *For criteria applicable to non-Medicare plans, please see CP.MP.31 Cosmetic and Reconstructive Procedures.*

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation® 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),^{1,2,3,4,5,6,7}

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2. Skin tag removal when located in an area that affects eyesight or in an area of friction with documentation of repeated irritation and bleeding (refer to Benefit Plan Contract for any coverage restrictions);⁸
3. Scar/keloid revision/removal when accompanied by pain unresponsive to conservative therapy and is recurrently infected, unstable, friable; or with functional impairment;⁹

II. It is the policy of Medicare Health Plans affiliated with Centene Corporation that cosmetic surgery is not medically necessary and not a covered benefit when performed for the sole purpose of improving appearance.²

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.¹⁰ 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.¹¹

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 considered not medically necessary.¹²

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 2024, 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. 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.

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 |

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|----------------------------|---|
| 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 |
| 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) |

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|----------------------------|--|
| 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 |
| 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 |

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|--------------------|--|
| 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) |
| 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 |

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|--------------------|---|
| 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, 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) |

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|--------------------|--|
| 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-opthalmia) |
| 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 |
| 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 |
|---|---------------|---------------|
| Policy created. Reviewed by external specialist. | 08/24 | 08/24 |
| Annual review. Updated verbiage in Note under Description section for clarity. Removed Criteria I.A.4. regarding certain procedures that may be covered if improving appearance is the only benefit. Coding and descriptions reviewed. References reviewed and updated. | 08/25 | 08/25 |
| Policy description updated to note that the applicable LCDs do not provide sufficient coverage criteria to consistently determine medical necessity in all clinically appropriate scenarios. | 12/25 | |

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Important Reminder

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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. The Health Plan 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. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. 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. The Health Plan 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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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