

Policy #: 068

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Title

Plastic Surgery

Reconstructive and Cosmetic Services

For treatment of hyperhidrosis, see policy #406

Note: All subscriber certificates exclude coverage for cosmetic services, and also restrict coverage for orthodontic and dental services. There are also exclusions for physical services that treat a mental condition, by improving appearance or self-esteem. Plastic surgery services are only covered when done to restore physical function, or to correct a physical problem resulting from some accidents, injuries, or birth defects.

Medical coverage for orthodontic and dental services related to cleft lip, cleft palate or both must be specified as covered in a member's subscriber certificate in order to access this benefit. Some BCBSMA dental plans may include orthodontic coverage. Please note that not all dental plans include orthodontic coverage and that each member's subscriber certificate should be reviewed for coverage specifics.

Subscriber certificate definition of Reconstructive surgery: This non-dental surgery is meant to improve or give back bodily function or correct a functional physical impairment that was caused by a birth defect, a prior surgical procedure or disease or an accidental injury. This also includes surgery to correct a deformity or disfigurement that was caused by an accidental injury.

The subscriber certificate also states that no coverage is provided for cosmetic services that are performed solely for the purpose of making you look better, whether or not these services are meant to make you feel better about your self or treat your *mental condition*. (For example, no coverage is provided for acne related services such as removal of acne cysts, injections to raise acne scars, cosmetic surgery and dermabrasion or other procedures to plane the skin; electrolysis; hair removal or restoration; and liposuction.)

The following information describes how we interpret the benefits outlined in the subscriber certificate:

When services are covered and not covered

General	Coverage	Indications
Complications of a Cosmetic Procedure	NO	Solely for the purpose of improving appearance, without restoring bodily function or correcting physical impairment. (The only benefits would be emotional or psychological.)
	YES	Complications arising from a non-covered service as well as from a medically necessary service when the treatment of the complication itself is medically necessary.

Congenital Deformities in Children	YES	Congenital and developmental deformities in children are covered when defects are severe or debilitating. These include cleft lip, cleft palate or both (see Face, Ears, Cheek, Mouth, Jaw, Chin Table later in this policy for further information), deforming hemangiomas, pectus excavatum, syndactyly, macrodactylia, and others. See policy for further specifics on each body part. Prior authorization is required. ¹
Lipectomy or Liposuction	NO	Surgery to remove fat. When the purpose is removal of fat for cosmetic reasons, this surgery is not covered.
Reconstructive surgery	YES	This surgery is meant to improve or give back bodily function or to correct a functional impairment that was caused by an accidental injury ^{5,2} , a birth defect ¹ or a prior surgical procedure or disease. ^{3,5}

¹ To receive benefits, the patient does **NOT** need to have been covered under BCBSMA at time of birth.

² Only the INITIAL reconstructive repair is covered, unless the procedure is normally done in stages.

³ Even if original procedure was cosmetic, as long as the complication resulted in physical or functional impairment

⁴ See the Harry Benjamin International Gender Dysphoria Association's "Standards Of Care For Gender Identity Disorders" Web address: <http://www.tc.umn.edu/nlhome/m201/colem001/hbigda>

⁵ See subscriber certificate

Head and Hair	coverage	indications
Hair removal <i>including Electrolysis and Laser</i>	NO	Removal of excessive hair, ¹ even if the excess hair is caused by a physical, medical disorder. Laser hair removal, without surgical intervention, as primary treatment of a pilonidal cyst. ⁶ Laser hair removal as primary treatment of a pilonidal cyst when it is used in combination with surgery. ⁶ Laser hair removal, without surgical intervention, as sole treatment to prevent recurrence of a pilonidal cyst. ⁶ Laser hair removal as treatment to prevent recurrence of a pilonidal cyst when it is used in combination with surgery. ⁶
	YES	If ingrown hairs are responsible for 2 or more painful cysts. ⁴ Excludes pilonidal cysts. ⁵
Hair transplants	YES	Scarring or baldness (alopecia) due to disease, trauma, ² previous therapy, ² or congenital scalp disorders.
	NO	Male pattern baldness
Wigs and Hair Protheses	YES	When hair loss is due to any of the following: chemotherapy, radiation therapy, infections, burns, traumatic injury, congenital baldness presence since birth, and medical conditions resulting in alopecia areata or alopecia totalis.
	NO	Male or female pattern baldness . Natural or premature aging

¹ People who perform electrolysis are not part of the BCBSMA network: We do not credential or contract with persons who perform these services.

² Only the INITIAL reconstructive repair is covered. If the procedure is normally done in stages with healing periods, then all stages are covered.

⁴ Recommendations from the Plastic and Reconstructive Surgery Summit, Medical Policy Group 1/01.

⁵ Based on expert opinion March 2007.

⁶ Based on expert opinion April 2010.

Skin	Coverage	indications
Chemical Peel	NO	Acne, acne scars, or uneven pigmentation. Except for Medicare HMO Blue and Medicare PPO Blue members: Payable if determined not to be cosmetic.
Dermabrasion	YES	For restoration after previous surgery or injury, ² by individual consideration. ⁴
	NO	Acne, acne scars, or uneven pigmentation
Injection of acne cysts	YES	For intralesional injection of painful acne cysts (<i>effective 4/1/00</i>).
Laser treatment of active acne	NO	Including, but not limited to, pulse dye laser treatment ¹⁶ .
Destruction of actinic keratoses	YES	When done using surgical or medical treatment methods including but not limited to: <ul style="list-style-type: none"> • Cryosurgery⁶ • Curettage⁶ • Excision⁶
Photodynamic Therapy for Dermatologic Applications	YES	For treatment of one of the following: ^{6,7,10,14} <ul style="list-style-type: none"> • Non-hyperkeratotic actinic keratoses of the face and scalp. • Superficial basal cell skin cancer only when surgery and radiation are contraindicated. Effective 9/08. • Bowen's disease (squamous cell carcinoma in situ) only when surgery and radiation are contraindicated. Effective 9/08. For photodynamic therapy for esophageal and lung cancer, see policy 51.
	NO	For other dermatologic applications, including, but not limited to, acne vulgaris, non-superficial basal cell carcinomas, hidradenitis suppurativa, or mycoses. ¹⁴ As a technique of skin rejuvenation, hair removal, or other cosmetic indications. ^{10,14}
Port Wine Stain laser treatments (tunable dye laser)	YES	<ul style="list-style-type: none"> • For port wine stains of the face and neck • For port wine stains or hemangiomas of other body parts when there is functional impairment related to the port wine stains.¹⁷
	NO	Treatment of other body parts is NOT covered for cosmetic reasons. Treatment of port wine stains with lasers in combination with photodynamic therapy or topical angiogenesis inhibitors is NOT covered. ¹⁷ Treatment is NOT covered for spider telangiectasias, spider nevus, spider angiomas, pyogenic granulomas.
Pulsed Dye Laser Treatments of Hypertrophic Scars	YES	Treatment of symptomatic hypertrophic scars when there is documented functional impairment. ³ Coverage effective 1/1/11
	NO	Treatment is NOT covered for cosmetic reasons, or when there is no documented functional impairment.
PUVA light therapy for vitiligo	See medical policy 911, Light Therapy for Vitiligo.	
Removal of excess skin	YES	After significant weight loss, in patients with stable weight, for any of the following: <ul style="list-style-type: none"> • Recurrent documented rashes or non-healing ulcers

		<ul style="list-style-type: none"> When there is a functional impairment. Documentation must be provided.
	NO	To improve appearance after weight loss, when there is no specific functional impairment from the excess skin
Rhytidectomy	YES	For correction of functional impairment from facial nerve palsy.
	NO	“Face-lift” to remove wrinkles; Botulinum Toxin (Botox®) when used for cosmetic reasons
Labiaplasty	YES	Documentation of medical necessity, i.e., recurrent documented rashes or non-healing ulcers or functional impairment in basic activities of daily living
	NO	For symmetry, hypertrophy, allow athletic achievements or a desired lifestyle; improve your appearance or how you feel about your appearance; or increase or enhance your environmental or personal comfort
Benign Lesions	YES	Documentation of medical necessity, i.e., bleeding, pain, recent changes in color or enlargement, exposed to frequent irritation.
	NO	To improve appearance
Scars	YES	(Surgery or intralesional steroid injection) Interference with normal bodily function OR causing pain.
	YES	For non dental restoration after accidental injury. ² Reconstructive surgery after accidental face and neck injuries may be covered in addition to the initial wound repair or treatment
	NO	Acne scars, or for purely cosmetic reasons
Tattoos	NO	Removal or application or treatment of decorative, such as eyebrow and eyelid tattoos, or self-inflicted tattoos
	YES	Tattooing of the areola as part of a nipple reconstruction following a covered mastectomy
Treatment of hyperhidrosis	YES	Treatment of Hyperhidrosis excluding Botulinum is addressed separately under policy #406. Effective 12/09. Botulinum Toxin for the Treatment of Hyperhidrosis is addressed separately under policy #405
Non-pharmacologic treatment of rosacea	YES	Excision and/or shaving of rhinophyma using a laser or other technique is considered medically necessary when there is documented evidence of bleeding, infection, or functional airway obstruction and it is reasonably likely the procedure will improve this condition. ¹ See Face, Ears, Cheek, Mouth, Jaw, Chin Table later in this policy for further information
	NO	Non-pharmacologic treatment of rosacea, including but not limited to laser and light therapy, dermabrasion, chemical peels, surgical debulking and electrosurgery, except, as noted above, for rhinophyma ¹³

¹ Coverage decision by Medical Director, Medical Policy Administration, based on expert opinion, 6/08.

² Only the INITIAL reconstructive repair is covered, unless the procedure is normally done in stages.

³ Coverage decision by Medical Director, Medical Policy Administration. Coverage is effective 1/1/11.

References:

1. Parrett BM, Donelan MB. Pulsed dye laser in burn scars: Current concepts and future directions. Burns (2009), doi: 10.1016/j.burns.2009.08.015

2. Donelan MB, Parrett BM, Sheridan, RL. Pulsed Dye Laser Therapy and Z-Plasty for Facial Burn Scars: The Alternative to Excision. *Ann Plast Surg* 2008 May; 60 (5) 480-6.

⁴ Recommendations from the Plastic and Reconstructive Surgery Summit, Medical Policy Group 1/01.

⁶ Based on CMS (Centers for Medicare and Medicaid Services) guidelines. See also:

<http://www.hcfa.gov/coverage/8b3-t4.htm>

⁷ FDA status: Levulan® Kerastick™ was FDA-approved in 1999 as a photodynamic therapy system for treatment of non-hyperkeratotic actinic keratoses of the face and scalp

¹⁰ Based on the Blue Cross Blue Shield Association National policy 2.01.44 Photodynamic Therapy for the Treatment of Actinic Keratoses and Other Skin Lesions. Policy statement changed to include coverage exclusion for Metvix® therapy, and to exclude coverage for Photodynamic therapy as a technique of skin rejuvenation, hair removal, or other cosmetic indications.

The Blue Cross Blue Shield Association National policy notes that PDT with topical ALA and exposure to blue light may be considered medically necessary as a treatment of non-hyperkeratotic actinic keratoses of the face and scalp. Medicare HMO Blue and Medicare PPO Blue members, coverage effective 7/19/01. For other plans, coverage effective 1/01/04.

References:

- Piacquadio DJ, Chen DM, Farber HF et al. Photodynamic therapy with aminolevulinic acid topical solution and visible blue light in the treatment of multiple actinic keratoses of the face and scalp: investigator-blinded, phase 3, multicenter trials. *Arch Dermatol* 2004;140(1):41-46.
- Pariser DM, Lowe NJ, Stewart DM et al. Photodynamic therapy with topical methyl aminolevulinate for actinic keratosis: results of a prospective randomized multicenter trial. *J Am Acad Dermatol* 2003;48(2):227-32.
- Freeman M, Vinciullo C, Francis D et al. A comparison of photodynamic therapy using topical methyl aminolevulinate (Metvix) with single cycle cryotherapy in patients with actinic keratosis: a prospective, randomized study. *J Dermatolog Treat* 2003; 14(2):99-106.
- Rhodes LE, de Rie M, Enstrom Y et al. Photodynamic therapy using topical methyl aminolevulinate vs surgery for nodular basal cell carcinoma: results of a multicenter randomized prospective trial. *Arch Dermatol* 2004;140(1):17-23.
- Salim A, Leman JA, McColl JH et al. Randomized comparison of photodynamic therapy with topical 5-fluorouracil in Bowen's disease. *Br J Dermatol* 2003;148(3):539-43.

¹³ **Non-pharmacologic treatment of rosacea:** Based upon the 2004 Blue Cross Blue Shield Association National policy 2.01.71.

References:

- Blount BW, Pelletier AL. Rosacea: a common, yet commonly overlooked, condition. *Am Fam Physician* 2002; 66(3):435-40. (Summary for patients in *Am Fam Physician* 2002; 66(3):442.)
- Rebora A. The management of rosacea. *Am J Clin Dermatol* 2002; 3(7):489-96.

2005 Update: Based on Blue Cross Blue Shield National policy 2.01.71 issued 12/05. Policy updated with literature review through October 2005. No additional studies were identified in the published medical literature that would prompt reconsideration of the policy statement, which remains unchanged.

Additional reference:

- Tan SR, Tope WD. Pulsed dye laser treatment of rosacea improves erythema, symptomatology, and quality of life. *J Am Acad Dermatol* 2004;51:592-99

2006 Update: Based on Blue Cross Blue Shield National Policy 2.01.71 issued 12/06.

Additional References:

4. Schroeter CA, Haaf-von Below S, Neumann HA. Effective treatment of rosacea using intense pulsed light systems. *Dermatol Surg* 2005; 31(10):1285-9.
5. van Zuuren EJ, Graber MA, Hollis S et al. Interventions for rosacea. *Cochrane Database Syst Rev* 2005;(3):CD003262.
6. National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS)
<http://www.niams.nih.gov/hi/topics/rosacea/rosacea.htm> June 2002 (accessed November 7, 2006; currently being updated)

2009 Update: Based upon BCBSA national policy 2.01.71 Non-Pharmacologic Treatment of Rosacea issued 12/09. A literature review update through October 2009; reference numbers 9 and 10 added (previous reference number 9 removed); without change in policy statement.

The MEDLINE database was searched for the period of January 2008 through October 2009. One comparative study on a non-pharmacologic treatment for rosacea was identified, a small randomized controlled trial. Neuhaus and colleagues included patients with moderate erythematotelangiectatic rosacea without active inflammatory papules and pustules who were at least 18 years old and had not received previous treatment with a laser or light-based device, were not undergoing treatment with a photosensitizing agent and had not had changes to their medication in the past 3 months. (9) The study used a split-face design; 29 patients were randomly assigned to receive treatment with a pulsed dye laser (PDL, Vbeam, Candela Corp) on one side of the face and an intense pulsed light (IPL, Quantum, Lumenis)) on the other side, and 4 patients each received either PDL or IPL on one side of the face and no treatment on the other. Laterality of treatment (right versus left side) was also randomly assigned. Patients underwent a total of 3 treatment sessions, 4 weeks apart and received their final evaluation 4 weeks after the 3rd treatment. Outcomes included an overall erythema score and overall telangiectasia score graded by a blinded observer, and patient self-report of symptoms. Only p-values, not actual scores were reported. There were no significant differences in outcomes between the pulsed dye laser and intense pulsed light groups. Thus, we cannot conclude that one of these treatments is superior to the other. To determine whether both are effective or ineffective, studies with a control group are needed. In this study, there were significantly lower erythema and telangiectasia scores for both IPL and PDL treatment compared to control ($p < 0.01$). However, the comparisons with no treatment included only 4 patients each and therefore these findings should be considered preliminary.

A search of ClinicalTrials.gov identified 1 active trial evaluating a non-pharmacologic treatment for rosacea. This is a single-blind, non-comparative study of combination therapy with calcium dobesilate and a pulsed dye laser and is currently recruiting patients. The final data collection date for the primary outcome measure is June 2010. (10)

In summary, the evidence to date remains insufficient to conclude that non-pharmacologic treatment for rosacea improves health outcomes and thus it is considered to be investigational.

References:

1. Blount BW, Pelletier AL. Rosacea: a common, yet commonly overlooked, condition. *Am Fam Physician* 2002; 66(3):435-40. (Summary for patients in *Am Fam Physician* 2002; 66(3):442.)
2. Rebora A. The management of rosacea. *Am J Clin Dermatol* 2002; 3(7):489-96.
3. Tan SR, Tope WD. Pulsed dye laser treatment of rosacea improves erythema, symptomatology, and quality of life. *J Am Acad Dermatol* 2004; 51(4):592-9.
4. Schroeter CA, Haaf-von Below S, Neumann HA. Effective treatment of rosacea using intense pulsed light systems. *Dermatol Surg* 2005; 31(10):1285-9.
5. van Zuuren EJ, Graber MA, Hollis S et al. Interventions for rosacea. *Cochrane Database Syst Rev* 2005; (3):CD003262.
6. National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS)
<http://www.niams.nih.gov/hi/topics/rosacea/rosacea.htm> June 2002 (accessed November 7, 2006; currently being updated)

7. van Zuuren EJ, Gupta AK, Gover MD et al. Systematic review of rosacea treatments. *J Am Acad Dermatol* 2007; 56(1):107-15.
8. Bryld LE, Jemec GB. Photodynamic therapy in a series of rosacea patients. *J Eur Acad Dermatol Venereol* 2007; 21(9):1199-202.
9. Neuhaus IM, Zane LT, Tope WD. Comparative efficacy of nonpurpuragenic pulsed dye laser and intense pulsed light for erythematotelangiectatic rosacea. *Dermatol Surg* 2009; 35(6):920-8.
10. ClinicalTrials.gov identifier NCT00945373.

BCBSMA has implemented editing *effective 9/1/07* to support non coverage of non-pharmacologic treatment of rosacea. The ICD-9 CM diagnosis 695.3 reports rosacea. If claims are submitted with this ICD-9 CM diagnosis and one of the following CPT codes: 15780-15783, 17000-17004 and 17110-17111, the service will reject as non covered.

¹⁴ Based on the Blue Cross Blue Shield Association National policy 2.01.44 Photodynamic Therapy for the Treatment of Actinic Keratoses and Other Skin Lesions, Issue 2/2005. Policy statement on Metvix[®] therapy changed to include coverage for non hyperkeratotic actinic keratoses of the face and scalp. Literature review update through February 2005. Updated policy to clarify coverage exclusion of photodynamic therapy with methyl aminolevulinate and exposure to red light is considered investigational for the treatment of other dermatologic applications, including but not limited to basal cell carcinomas, Bowen's disease, acne vulgaris, mycoses, or squamous carcinoma. Updated policy to clarify coverage exclusion of photodynamic therapy with topical ALA and exposure to blue or red light is considered investigational for other dermatologic applications, including, but not limited, acne vulgaris, squamous carcinoma, basal carcinoma, hidradenitis suppurativa, mycoses or Bowen's disease.

2006 Update: Based on Blue Cross Blue Shield National policy 2.01.44, Photodynamic Therapy for the Treatment of Actinic Keratoses and Other Skin Lesions, issued 7/06, a review and literature search for the period of 2005 through July 2006 did not identify any clinical trials that would alter the conclusions reached above. Comparative trials for patients with acne vulgaris involved very few participants. A recent study in 102 patients with basal cell cancer showed promising results; however, there was no comparative group. (13) Therefore, the policy statements are unchanged.

References:

1. Product Insert: Levulan Kerastick: <http://www.fda.gov/cder/foi/label/1999/20965LBL.pdf>
2. Kurwa HA, Yong-Gee SA, Seed PT et al. A randomized paired comparison of photodynamic therapy and topical 5-fluorouracil in the treatment of actinic keratoses. *J Am Acad Dermatol* 1999; 41(3 pt 1):414-8.
3. Medicare Transmittal Number 145. Accessible at www.cms.hhs.gov/manuals/pm_trans/R145CIM.pdf
4. Piacquadio DJ, Chen DM, Farber HF et al. Photodynamic therapy with aminolevulinic acid topical solution and visible blue light in the treatment of multiple actinic keratoses of the face and scalp: investigator-blinded, phase 3, multicenter trials. *Arch Dermatol* 2004;140(1):41-6.
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6. Freeman M, Vinciullo C, Francis D et al. A comparison of photodynamic therapy using topical methyl aminolevulinate (Metvix) with single cycle cryotherapy in patients with actinic keratosis: a prospective, randomized study. *J Dermatolog Treat* 2003; 14(2):99-106.
7. Rhodes LE, de Rie M, Enstrom Y et al. Photodynamic therapy using topical methyl aminolevulinate vs surgery for nodular basal cell carcinoma: results of a multicenter randomized prospective trial. *Arch Dermatol* 2004; 140(1):17-23.
8. Salim A, Leman JA, McColl JH et al. Randomized comparison of photodynamic therapy with topical 5-fluorouracil in Bowen's disease. *Br J Dermatol* 2003; 148(3):539-43.
9. FDA Professional Labeling for Metvix. <http://www.fda.gov/cdrh/pdf/p010061c.pdf> .
10. Gold M, Bridges TM, Bradshaw VL et al. ALA-PDT and blue light therapy for hidradenitis suppurativa. *J Drugs Dermatol* 2004; 3(1 suppl):S32-5.

11. Pollock B, Turner D, Stringer MR et al. Topical aminolevulinic acid-photodynamic therapy for the treatment of acne vulgaris: a study of clinical efficacy and mechanism of action. *Br J Dermatol* 2004; 151(3):616-22.
12. Calzavara-Pinton PG, Venturini M, Capezzer R et al. Photodynamic therapy of interdigital mycoses of the feet with topical application of 5-aminolevulinic acid. *Photodermatol Photoimmunol Photomed* 2004; 20(3):144-7.
13. Vinciullo C, Elliott T, Francis D, et al. Photodynamic therapy with topical methyl aminoaevalinate for 'difficult-to-treat' basal cell carcinoma. *Br J Dermatol.* 2005 Apr;152(4):765-72.

2007 Update: A search of the MEDLINE database was performed for the period of April 2006 through May 2007. With recently published guidelines, this review focused particularly on the use of PDT for low-risk non-melanoma skin cancers, including superficial basal cell carcinoma (BCC) and Bowen's disease. (14) The search identified a number of review articles on the use of PDT for basal and squamous cell carcinoma of the skin and 1 randomized controlled trial. Additional papers published prior to 2006 were identified from citations in the review articles. Also reviewed were studies comparing PDT with other treatments for actinic keratosis.

Actinic Keratosis Morton and colleagues conducted an industry-sponsored 25 center randomized left-right comparison of single photodynamic treatment and cryotherapy in 119 subjects. (15) At 12-week follow-up, PDT resulted in a significantly larger rate of cured lesions compared with cryotherapy (86.9% vs. 76.2% cured). Lesions with a non-complete response were retreated after 12 weeks; a total of 108 of 725 lesions (14.9%) received a second PDT session; 191 of 714 lesions (26.8%) required a second cryotherapy treatment. At 24 weeks, the groups showed equivalent clearance (85.8% vs. 82.5%). Thus, approximately 12% more cryotherapy sessions were required to achieve comparable outcomes to PDT. Skin discomfort was reported to be greater with PDT than with cryotherapy. Investigator-rated cosmetic outcomes showed no difference in the percentage of subjects with poor cosmetic outcomes (0.3% vs. 0.5%), with more subjects rated as having excellent outcomes at 24 weeks after PDT (77.2% vs. 49.7%). With PDT, 22.5% had cosmetic ratings of fair or good compared to 49.9% for cryotherapy. Subjects perceived PDT to have better efficacy and cosmetic outcome. Together with the randomized trial described above (6), the data suggest that PDT may have improved efficacy and cosmetic outcomes compared with cryotherapy.

Tschen and colleagues reported 12-month follow-up from an industry sponsored phase IV multicenter clinical trial of PDT for actinic keratosis. (16) Of 110 patients enrolled, 98 (89%) completed the study. The percentage of cleared lesions was 86% at 4 months and 78% at 12 months, with a recurrence rate of 19% for histologically confirmed actinic keratosis lesions. Per patient analysis showed that 60% of the patients required a second treatment.

Basal and Squamous Cell Carcinoma An updated Cochrane review evaluated surgical, destructive (including PDT), and chemical interventions for basal cell carcinoma. (17) The authors concluded that surgery and radiotherapy appeared to be the most effective treatments, with the best results being obtained with surgery. In comparison with cryotherapy, PDT was shown to have greater participant tolerability and cosmetic outcomes. The authors concluded that current efficacy data does not support the introduction of PDT for the treatment of BCC. However, this review did not distinguish between BCC subtypes.

The literature on PDT and superficial BCC, which consists of 1 controlled trial published as an abstract and 10 uncontrolled trials, suggests high initial clearance rates for lesions on the face, trunk, and extremities (reviewed in reference 14). No trials were identified that directly compared long-term recurrence rates following PDT or surgery for superficial BCC. In uncontrolled trials, recurrence rates for PDT-treated superficial BCC lesions have been reported in the range of 18% to 22% at 48 months. (14) This can be compared with rates around 1% reported at 48 months following surgical excision. (17) A study that compared PDT with cryotherapy for superficial BCC has been published in abstract form. (18) Lesion recurrence rates were reported to be similar after 48 months (22% for PDT vs. 19% for cryotherapy). Overall cosmetic outcome at 48 months was rated as excellent or good for 88% of patients in the PDT group and 62% of patients in the cryotherapy group.

A multicenter randomized trial with 225 patients (from 40 hospital outpatient dermatology clinics in 11 European countries) compared MAL with cryotherapy or 5-FU for the treatment of Bowen's disease (squamous cell carcinoma in situ) with lesions on the face or scalp (23%), neck or trunk (12%), or extremities (65%). (19) Unblinded assessment of lesion clearance found PDT to be non-inferior to cryotherapy and 5-FU (93%, 86%, 83%, respectively) at 3 months, and superior to cryotherapy and 5-FU (80%, 67%, 69%, respectively) at 12 months. Cosmetic outcome at 3 months was rated higher for PDT than the standard non-surgical treatments by both investigators and blinded evaluators, with investigators rating cosmetic outcome as good or excellent in 94% of patients treated with MAL-PDT, 66% of patients treated with cryotherapy, and 76% of those treated with 5-FU. A randomized study by Salim and colleagues, which found greater clearing and fewer adverse eczematous reactions with PDT as compared with 5-FU for treatment of Bowen's disease, was described above. (8)

Current practice guidelines from the National Comprehensive Cancer Network (NCCN) state that, "Surgical approaches often offer the most effective and efficient means for accomplishing cure, but considerations of function, cosmesis, and patient preference may lead to choosing radiation therapy as primary treatment in order to achieve optimal overall results." (20) In patients with superficial BCC or Bowen's disease for whom surgery or radiation is contraindicated or impractical, "topical therapies such as 5-fluorouracil, imiquimod, photodynamic therapy (e.g., porfimer sodium, topical amino levulinic acid (ALA)), or vigorous cryotherapy may be considered, even though the cure rate may be lower."

The International Society for Photodynamic Therapy in Dermatology published consensus-based guidelines on the use of PDT for non-melanoma skin cancer. (14) Based on both efficacy and cosmetic outcome, they recommended PDT as a first-line therapy for actinic keratosis. The guideline authors considered ALA to not have sufficient tissue penetration for nodular basal cell carcinoma. Based on 2 randomized-controlled and 3 open-label studies, it was concluded that MAL-PDT can be effective for nodular basal cell carcinoma lesions less than 2 mm in depth if debulked. The guideline recommended PDT for superficial basal cell carcinoma as "a viable alternative when surgery would be inappropriate or the patient or physician wishes to maintain normal skin appearance." The report concluded that PDT is at least as effective as cryotherapy or 5-FU for Bowen's disease, but that there is insufficient evidence to support the routine use of topical PDT for squamous cell carcinoma.

Literature on the use of PDT for acne consists of a several small (n = 30 or fewer per group) randomized controlled trials from outside of the United States. Results from these initial studies suggest a reduction in lesion count but significant adverse effects of MAL treatment. In 1 study 30% of subjects dropped out of the MAL group due to pain. (21) Due to the small number of patients studied and high incidence of adverse effects, PDT for acne is considered investigational.

References:

14. Braathen LR, Szeimies RM, Basset-Seguín N et al. Guidelines on the use of photodynamic therapy for nonmelanoma skin cancer: an international consensus. *International Society for Photodynamic Therapy in Dermatology*, 2005. *J Am Acad Dermatol* 2007; 56(1):125-43.
15. Morton C, Campbell S, Gupta G et al; AKtion Investigators. Intraindividual, right-left comparison of topical methyl aminolaevulinic acid-photodynamic therapy and cryotherapy in subjects with actinic keratoses: a multicentre, randomized controlled study. *Br J Dermatol* 2006; 155(5):1029-36.
16. Tschien EH, Wong DS, Pariser DM et al; Phase IV ALA-PDT Actinic Keratosis Study Group. Photodynamic therapy using aminolaevulinic acid for patients with nonhyperkeratotic actinic keratoses of the face and scalp: phase IV multicentre clinical trial with 12-month follow up. *Br J Dermatol* 2006; 155(6):1262-9.
17. Bath-Hextall FJ, Perkins W, Bong J et al. Interventions for basal cell carcinoma of the skin. *Cochrane Database Syst Rev*. 2007; (1):CD003412.
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19. Morton C, Horn M, Leman J et al. Comparison of topical methyl aminolevulinate photodynamic therapy with cryotherapy or Fluorouracil for treatment of squamous cell carcinoma in situ: Results of a multicenter randomized trial. *Arch Dermatol* 2006; 142(6):729-35.
20. Practice Guidelines in Oncology – v.1.2007 Basal Cell and Squamous Cell Skin Cancers
http://www.nccn.org/professionals/physician_gls/PDF/nmsc.pdf
21. Wiegell SR, Wulf HC. Photodynamic therapy of acne vulgaris using methyl aminolaevulinate: a blinded, randomized, controlled trial. *Br J Dermatol* 2006;154(5):969-76.

2008 Update: Based on Blue Cross Blue Shield National policy 2.01.44, Photodynamic Therapy for the Treatment of Actinic Keratoses and Other Skin Lesions, issued 8/08. Literature review update through June 2008. References were reordered. Reference numbers 17, 19, 22 and 24 added; policy statements unchanged.

References:

- a. Wiegell SR, Haedersdal M, Philipsen PA et al. Continuous activation of PpIX by daylight is as effective as and less painful than conventional photodynamic therapy for actinic keratoses; a randomized, controlled, single-blinded study. *Br J Dermatol* 2008; 158(4):740-6.
19. Szeimies R, Ibbotson S, Murrell D, et al; on behalf of the Excilight Study Group. A clinical study comparing methyl aminolevulinate photodynamic therapy and surgery in small superficial basal cell carcinoma (8-20 mm), with a 12-month follow-up. *J Eur Acad Dermatol Venereol* 2008 Jul 2 [Epub ahead of print].
22. Rhodes LE, de Rie MA, Leifsdottir R et al. Five-year follow-up of a randomized, prospective trial of topical methyl aminolevulinate photodynamic therapy vs surgery for nodular basal cell carcinoma. *Arch Dermatol* 2007; 143(9):1131-6.
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2009-2010 Update: Based on Blue Cross Blue Shield National policy 2.01.44, Dermatologic Applications of Photodynamic Therapy issued 1/2010. The policy was updated with a search of the MEDLINE database for the period June 2008 through October 2009. Reference numbers 24-29 were added; policy statements unchanged.

References:

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26. Basset-Seguín N, Ibbotson SH, Emtestam L et al. Topical methyl aminolaevulinate photodynamic therapy versus cryotherapy for superficial basal cell carcinoma: a 5 year randomized trial. *Eur J Dermatol* 2008; 18(5):547-53.
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28. NCCN. Practice Guidelines in Oncology- v1. 2009 Basal Cell and Squamous Cell Skin Cancers.
29. Morton CA, McKenna KE, Rhodes LE; British Association of Dermatologists Therapy Guidelines and Audit Subcommittee and the British Photodermatology Group. Guidelines for topical photodynamic therapy: update. *Br J Dermatol*. 2008; 159(6):35-48.

¹⁶Based upon BCBSA national policy 2.01.69 Laser Treatment of Active Acne, issued 4/07. This BCBSA policy was issued as a new policy 11/04.

Laser Treatment of Active Acne: Based upon BCBSA policy, this treatment is considered investigational.

Rationale:

Two recently published randomized controlled trials (RCT) on pulsed dye laser for the treatment of acne (in which significant acne therapies were withheld from patients for a period prior to and during the course of the trials) have reported conflicting results. Seaton et al reported on a double-blind RCT of 41 adults with mild to moderate facial inflammatory acne (i.e., a Leeds acne severity score of between 2 and 7). (1) Patients were randomized to receive a single low fluence pulsed dye laser treatment or sham treatment. At 12 weeks, Leeds acne scores fell from 3.8 to 1.9 in the treatment group and from 3.6 to 3.5 in the control group. Total lesion counts fell by 53% and 9% and inflammatory lesion counts fell by 49% and 10% in the laser treatment group and control group, respectively. While the authors reported statistically significant improvements, they concluded that “laser treatment should be further explored as an adjuvant or alternative to daily conventional pharmacological treatments.”

In contrast, Orringer et al reported on a single-blind, split-face RCT of 40 patients (aged 13 years or older with a Leeds acne score of 2 or greater) randomized to receive either 1 or 2 sessions of pulsed dye laser treatment (3 J/cm² fluence) to half of the face with the opposite, non-treated side serving as the control. (2) At 12 weeks, changes in lesion counts (including pustules, comedones, macules, cysts, and papules) and mean Leeds acne scores were not significantly different for the treated versus untreated sides of the face. The authors concluded that “...additional well designed studies are needed before the use of pulse dye laser becomes a part of acne therapy.”

The small size and conflicting results of the Seaton and Orringer RCTs do not allow conclusions as to the benefits of pulsed dye laser therapy for acne. In addition, no RCTs with long-term follow-up have compared laser treatment outcomes to standard acne treatments to determine appropriate treatment approaches.

The American Academy of Dermatology indicates on its Web site that “several laser and light treatments are available to treat acne. Some of these laser and light treatments target only one factor that causes acne. For many patients, this is not a comprehensive treatment for resolving their acne. A dermatologist can determine if laser or light treatment is appropriate for a patient. Advantages to laser and light treatments include not having to remember to apply or take any medication and the ability to treat hard-to-reach areas, such as the back. However, laser and light treatments can be quite expensive, and long-term effectiveness has not been proven.” (3) In addition, in a recent review in the Journal of the American Academy of Dermatology, Harper noted that while lasers are being used in individuals with acne, “Clinical trials are few in number and offer no long-term follow-up to date.” (4)

2005 Update: A literature search of the MEDLINE database for the period of 2004 through October of 2005 did not identify any additional literature that would prompt reconsideration of the policy; therefore, the policy statement remains unchanged.

2006-2007 Update: A search of the MEDLINE database was performed for the period of September 2005 through February 2007. One RCT assessed the efficacy of a 1320-nm laser (CoolTouch II) in 46 patients in a split-face design. (5) Laser treatment was given once every 3 weeks, with blinded evaluation by a panel of 3 dermatologists (from photographs taken at 7 and 14 weeks). Thirty patients completed the 14-week assessment (35% dropout); data were carried forward to adjust for subjects who may have dropped out of the study due to lack of effect. The authors report that the treated side remained unchanged at 0.22 cysts (10 total cysts in 46 subjects) while the untreated side increased from 0.27 to 0.70 cysts. Subjective patient reports (of 37 who completed at least the 7-week assessment; not blinded to treatment) favored the treated side over the control side for a decrease in acne (59%) and oily skin (54%). No differences were found between the treated and untreated sides in the number of papules, pustules, open comedones, or closed comedones at 14 weeks.

The search also identified a variety of pilot studies with less than 30 subjects. Investigators have been evaluating the most effective treatment parameters, varying such factors as dose and wavelength. (6, 7) The exploratory nature of these studies, combined with the mixed results of the RCTs described above, indicates that laser treatment of acne is investigational.

References:

1. Seaton ED, Charakida A, Mouser PE et al. Pulsed-dye laser treatment for inflammatory acne vulgaris: randomized controlled trial. *Lancet* 2003; 362(9393):1347-52.
2. Orringer JS, Kang S, Hamilton T et al. Treatment of acne vulgaris with a pulsed dye laser: a randomized controlled trial. *JAMA* 2004; 291(23):2834-9.
3. <http://www.skincarephysicians.com/acnenet/PhysicalProcedures.html> .
4. Harper JC. An update on the pathogenesis and management of acne vulgaris. *J Am Acad Dermatol* 2004; 51(1 suppl):S36-8.
5. Orringer JS, Kang S, Maier L et al. A randomized, controlled, split-face clinical trial of 1320-nm Nd:YAG laser therapy in the treatment of acne vulgaris. *J Am Acad Dermatol* 2007; 56(3):432-8.
6. Jih MH, Friedman PM, Goldberg LH et al. The 1450-nm diode laser for facial inflammatory acne vulgaris: dose-response and 12-month follow-up study. *J Am Acad Dermatol* 2006; 55(1):80-7.
7. Baugh WP, Kucaba WD. Nonablative phototherapy for acne vulgaris using the KTP 532 nm laser. *Dermatol Surg* 2005; 31(10):1290-6.

2008 Update: A search of MEDLINE database for the period of March 2007 through April 2008 identified a systematic review on the use of various lasers and other light sources for the treatment of acne. (8) Sixteen randomized controlled trials (RCT) and 3 controlled trials were included in the review; most of the studies utilized intraindividual (split-face) design. The review found that RCTs comparing lasers with sham treatment yielded ambiguous results, while the trials of photodynamic therapy with intense pulsed laser (IPL) versus IPL alone favored photodynamic therapy (up to 68% improvement). Side effects from optical treatments included pain, erythema, edema, crusting, hyperpigmentation, and pustular eruptions. The authors noted that topical and systemic treatments (e.g., retinoids, antimicrobials, and antibiotics) have been documented to be beneficial (up to 90% improvement) for the treatment of acne. The available literature provides very limited data (small series with varying techniques) for this technology, it is still considered investigational. The policy statement is unchanged.

Additional Reference:

- a. Haedersdal M, Togsverd-Bo K, Wiegell SR et al. Long-pulsed dye laser versus long-pulsed dye laser-assisted photodynamic therapy for acne vulgaris: a randomized controlled trial. *J Am Acad Dermatol* 2008; 58(3):387-94.

¹⁷Based on BCBSA National policy 7.01.40, Laser Treatment of Port Wine Stains, reviewed 6/2011. Effective 3/1/2011.

Eye	coverage	indications
Blepharoplasty, upper lids (including those done by laser)	YES	Blepharochalasis with documented visual impairment ¹ OR Accidental injury or traumatic scars ² OR Functional deformity from disease, such a Grave’s disease or previous treatment. ³
	NO	To improve appearance.
Repair brow ptosis	YES	Visual impairment. ¹
Blepharoplasty, lower lids	YES	Accidental injury or traumatic scars ² OR Functional deformity from disease or previous treatment. ³
	NO	Lower lid blepharochalasis

¹ Upper field must improve by at least 20 degrees with eyelid taped compared to visual field with untaped lid, **OR** visual field obstruction by lid or brow must limit upper field to within 30 degrees of fixation.

² Only the INITIAL reconstructive repair is covered. If the procedure is normally done in stages with healing periods, then all stages are covered.

³ As described in rider 99-804.

Nose	coverage	indications
Excision or Shaving of Rhinophyma	YES	Excision and/or shaving of rhinophyma using a laser or other technique is considered medically necessary when there is documented evidence of bleeding, infection, or functional airway obstruction and it is reasonably likely the procedure will improve this condition. ^{1,3}
Rhinoplasty	YES	<ul style="list-style-type: none"> Airway obstruction¹ from deformities due to disease, congenital abnormality, or previous therapy² that will not respond to septoplasty alone OR Reconstruction for a causally related accidental injury.²
	NO	Familial external nasal deformity or cosmetic reasons

¹ Requires documentation

² See subscriber certificate

³ Coverage decision by Medical Director, Medical Policy Administration, based on expert opinion, 6/08.

Face, Ears, Cheek, Mouth, Jaw, Chin	coverage	Indications
Cleft Lip, Cleft Palate or Both Repair	YES	<p>These congenital defects are covered. Prior authorization is required for inpatient services.⁸</p> <p>Orthodontic and dental services are covered only when the member's subscriber certificate specifies coverage or contains benefits for this category of procedure or services.</p> <p>When the subscriber certificate indicates coverage for orthodontic and dental services for cleft lip, cleft palate or both, these services are considered medically necessary for the diagnoses that are listed in footnote #9.</p>
Facial Plastic Surgery (see below)	YES	<ul style="list-style-type: none"> Initial restoration of appearance after accidental injury,² OR To restore bodily function or correct a functional impairment caused by: an accidental injury;⁷ a birth defect;¹ a prior surgical procedure; or disease.^{7,3}
Mandibular or Maxillary Osteotomy/plasty	NO	For familial jaw deformities, or "weak chin"
	YES	For prognathism or micrognathism with documented severe handicapping malocclusion. ⁴
Other Osteotomy/plasty	YES	Including Crouzon's syndrome, Treacher Collin's dysostosis, Romberg's disease with severe facial deformity, and other significant cranio-facial. ⁵
Mentoplasty with or without implant	NO	For familial chin deformities, or "weak chin"
Orthodontics and Dental Services	NO	Except for cleft lip, cleft palate or both, orthodontics and dental services are not covered on our medical plans, or as part of a coordinated treatment plan. Please refer to the member's subscriber certificate. ⁶
Otoplasty	YES	For unilateral or bilateral congenital absence of the ear (anotia), or severe microtia (for example, grade III).
	NO	Keloids, clefts, or other consequences of ear piercing, or For "lop ears" or protruding ears.
Rhytidectomy	YES	For correction of functional impairment from facial nerve palsy. ⁷
	NO	"Face-lift" to remove wrinkles

¹ The degree to which ears are protruding or lopped is not objective.

² Only the INITIAL reconstructive repair is covered. If the procedure is normally done in stages with healing periods, then all stages are covered.

³ Even if original procedure was cosmetic, as long as the complication resulted in physical functional impairment.

⁴ Requires documentation.

⁵ Including Crouzon's syndrome, Treacher Collin's dysostosis, Romberg's disease with severe facial deformity, and other significant cranio-facial abnormalities.

⁶ Medical coverage for orthodontic or dental services related to cleft lip, cleft palate or both must be specified as covered in a member's subscriber certificate in order to access this benefit. Some BCBSMA dental plans may include orthodontic coverage. Please note that not all dental plans include orthodontic coverage and that each member's subscriber certificate should be reviewed for coverage specifics..

⁷ See subscriber certificate

⁸ To receive benefits, the patient does **NOT** need to have been covered under BCBSMA at time of birth.

⁹ The following diagnoses for cleft lip, cleft palate or both are considered medically necessary for orthodontic and dental procedures when these services are specified as covered in a member's subscriber's certificate:

749.00 Unspecified cleft palate

749.01 Unilateral cleft palate, complete

749.02 Unilateral cleft palate, incomplete

749.03 Bilateral cleft palate, complete

749.04 Bilateral cleft palate, incomplete

749.10 Cleft lip unspecified

749.11 Cleft lip unilateral complete

749.12 Cleft lip unilateral incomplete

749.13 Cleft lip Bilateral incomplete

749.14 Cleft lip Bilateral incomplete

749.20 Unspecified cleft palate with cleft lip

749.21 Unilateral cleft palate with cleft lip, complete

749.22 Unilateral cleft palate with cleft lip, incomplete

749.23 Bilateral cleft palate with cleft lip, complete

749.24 Bilateral cleft palate with cleft lip, incomplete

749.25 Other combinations of cleft palate with cleft lip

ICD-9 Diagnosis Codes

ICD-9-CM diagnosis codes:	Code Description
749.00	Cleft palate, unspecified
749.01	Cleft palate, unilateral, complete
749.02	Cleft palate, unilateral, incomplete
749.03	Cleft palate, bilateral, complete
749.04	Cleft palate, bilateral, incomplete
749.10	Cleft lip, unspecified
749.11	Cleft lip, unilateral, complete
749.12	Cleft lip, unilateral, incomplete
749.13	Cleft lip, bilateral, complete
749.14	Cleft lip, bilateral, incomplete
749.20	Cleft palate with cleft lip, unspecified
749.21	Cleft palate with cleft lip, unilateral, complete
749.22	Cleft palate with cleft lip, unilateral, incomplete
749.23	Cleft palate with cleft lip, bilateral, complete
749.24	Cleft palate with cleft lip, bilateral, incomplete

749.25	Other combinations of cleft palate with cleft lip
749.1	Cleft lip
749.2	Cleft palate with cleft lip

ICD-10 Diagnosis Codes

ICD-10-CM diagnosis codes:	Code Description
Q35.1	Cleft hard palate
Q35.3	Cleft soft palate
Q35.5	Cleft hard palate with cleft soft palate
Q35.9	Cleft palate, unspecified
Q35.7	Cleft uvula
Q36.9	Cleft lip, unilateral
Q36.1	Cleft lip, median
Q36.0	Cleft lip, bilateral
Q37.9	Unspecified cleft palate with unilateral cleft lip
Q37.1	Cleft hard palate with unilateral cleft lip
Q37.3	Cleft soft palate with unilateral cleft lip
Q37.5	Cleft hard and soft palate with unilateral cleft lip
Q37.0	Cleft hard palate with bilateral cleft lip
Q37.2	Cleft soft palate with bilateral cleft lip
Q37.4	Cleft hard and soft palate with bilateral cleft lip
Q37.8	Unspecified cleft palate with bilateral cleft lip

Breast	coverage	indications
COVERAGE FOR MASTECTOMY AND BREAST CONSERVATION THERAPY PATIENTS		
Reconstruction after mastectomy, breast conservation therapy (BCT) and diagnostic procedures causing deformity of the breast	YES	<p>When the mastectomy, BCT or other diagnostic procedures causing deformity of the breast is performed in connection with:</p> <ul style="list-style-type: none"> • Breast cancer, or • the evaluation of breast cancer or suspected breast cancer, or • the prevention of development of breast cancer in high risk patients^{7,9} <p>For reconstruction of the breast on which the mastectomy, BCT or other diagnostic procedures causing deformity of the breast was performed</p> <ul style="list-style-type: none"> • For surgery and reconstructive surgery on the unaffected breast to produce a symmetrical appearance • For prostheses and physical complications of all stages of mastectomy*, BCT or other diagnostic procedures causing deformity, including lymphedema treatment. <p>NOTE: We cover tattooing of the areola as part of the nipple reconstruction following a covered mastectomy.</p> <p>*Physical complications of a staged mastectomy may include, but is not limited to, abdominal scar revision/release related to prior tissue transfer needed for breast reconstruction.</p>
Allgraft material for use	YES	In accordance with the Women's Health and Cancer Rights Act of

in breast reconstructive surgery		1998, when performed as a breast reconstruction procedure following or in connection with mastectomy, breast conservation therapy (BCT) or other diagnostic procedures causing deformity of the breast, in connection with breast cancer, evaluation of breast cancer or suspected breast cancer, or to prevent development of breast cancer in high risk patients. ⁷
COVERAGE FOR OTHER PATIENTS		
Augmentation Mammoplasty	NO	To enlarge small but otherwise normal and symmetrical breasts, or to create symmetry between normal breasts.
	YES	For Poland's Syndrome (congenital absence of one breast), or severe (a minimum of 1 cup size difference) breast asymmetry. ⁵ Surgery on the contralateral breast is a once in a lifetime benefit only.
Congenital Chest Wall Deformity	YES	To correct pectus excavatum or pectus carinatum in children, up to 18 years old, when future cardiovascular or respiratory compromise is possible. Inclusion criteria: A Haller index of 3.2 or greater (which is suggested to be a future predictor of cardiovascular compromise) for pectus excavatum or when based upon the requesting physician's clinical judgment the magnitude of the deformity places the patient at risk of impending cardiovascular or respiratory compromise. ¹⁰
	NO	To correct pectus excavatum or pectus carinatum performed for cosmetic reasons.

<p>Breast Reduction Surgery</p> <p>► Gynecomastia Reconstruction</p> <p>► Reduction Mammoplasty</p>	<p>YES</p>	<p>For men or women to reduce the size of breasts that are causing significant physical symptoms; severe gynecomastia in patients with Klinefelter’s disease (disease must have supporting documentation (i.e. chromosome analysis). Women must be at least 16 years old or have evidence that puberty is complete, such as wrist radiographs or height and weight chart documentation.</p> <p>Gynecomastia reduction and reduction mammoplasty are reviewed for medical necessity through a prior authorization process for Managed Care Plans.</p> <p>Physicians may submit the following information:</p> <ul style="list-style-type: none"> • Symptomatology and duration (The information submitted should indicate the nature of the member’s significant physical symptoms.) • Height • Anticipated amount of breast tissue removed from each breast. <p>Physicians may submit the following additional information:</p> <ul style="list-style-type: none"> • Weight • Body frame (small, medium, large) • Photograph. <p>The required minimum amount of grams of breast tissue to be removed depends upon the member’s height:</p> <table border="1" data-bbox="685 1077 1421 1455"> <thead> <tr> <th>Patient height</th> <th>Estimated minimum grams of tissue removed from each breast</th> </tr> </thead> <tbody> <tr> <td>under 5 feet</td> <td>300 gm</td> </tr> <tr> <td>5’0’’ up to but not including 5’4’’</td> <td>325 gm</td> </tr> <tr> <td>5’4’’ up to but not including 5’7’’</td> <td>350 gm</td> </tr> <tr> <td>5’7’’ up to but not including 5’9’’</td> <td>375 gm</td> </tr> <tr> <td>over 5’9’’</td> <td>400 gm</td> </tr> </tbody> </table> <p><i>According to the 1996 Metropolitan Life Insurance Company charts, the most suitable candidates for reduction mammoplasty are within 10-12% of ideal body weight. It is at the discretion of the requesting physician to determine if the member’s pre-surgical weight will have a negative impact on the clinical outcome of the planned surgery, i.e., relief of member’s symptoms.</i></p> <p>Authorization is required for all Managed Care Plans, see below.⁴</p>	Patient height	Estimated minimum grams of tissue removed from each breast	under 5 feet	300 gm	5’0’’ up to but not including 5’4’’	325 gm	5’4’’ up to but not including 5’7’’	350 gm	5’7’’ up to but not including 5’9’’	375 gm	over 5’9’’	400 gm
Patient height	Estimated minimum grams of tissue removed from each breast													
under 5 feet	300 gm													
5’0’’ up to but not including 5’4’’	325 gm													
5’4’’ up to but not including 5’7’’	350 gm													
5’7’’ up to but not including 5’9’’	375 gm													
over 5’9’’	400 gm													

	NO	Reduction mammoplasty (breast reduction surgery) performed on pubertal females. ¹¹ NOTE: For puberty definition, please refer to the definition section of this policy.
Implant Removal	YES	When medically required due to infection; complications of leakage, or rupture; capsular contracture, or pain. ¹
Implant Repositioning	NO	To reposition a displaced implant.
	YES	In accordance with the Women's Health and Cancer Right's Act of 1998, when performed as a breast reconstruction procedure following or in connection with mastectomy, breast conservation therapy (BCT) or other diagnostic procedures causing deformity of the breast, in connection with breast cancer, evaluation of breast cancer or suspected breast cancer, or to prevent development of breast cancer in high risk patients. ⁷
Inverted Nipple Correction	NO	To correct nipple inversion. ⁶
	YES	In accordance with the Women's Health and Cancer Right's Act of 1998, when performed as a breast reconstruction procedure following or in connection with mastectomy, breast conservation therapy (BCT) or other diagnostic procedures causing deformity of the breast, in connection with breast cancer, evaluation of breast cancer or suspected breast cancer, or to prevent development of breast cancer in high risk patients. ⁷

Mastectomy as Prophylaxis for Cancer ^{9, 12}	YES	<p>I. For women at higher than normal risk for breast cancer. Examples of higher risk include:^{8, 12}</p> <ul style="list-style-type: none"> • Personal history of breast cancer • Patients with a known BRCA 1 or BRCA 2 mutation • Patients with a BRCA 1 or BRCA 2 mutation in a family member with breast or ovarian cancer • Two or more first-degree relatives with breast cancer • One first-degree relative and two more second-degree or third-degree relatives with breast cancer • One first-degree relative with breast cancer before the age of 45 and one other relative with breast cancer • Two second-degree or third-degree relatives with breast cancer and one or more with ovarian cancer • One second-degree or third-degree relative with breast cancer and two or more with ovarian cancer • Three or more second-degree or third-degree relatives with breast cancer • One first-degree relative with bilateral breast cancer. <p>For the following medically necessary indications for patients at high risk for breast cancer: ¹² Effective 9/1/09.</p> <ul style="list-style-type: none"> • Two or more first-degree relatives with ovarian cancer • One first-degree relative with breast cancer and one or more relatives with ovarian cancer • Two second-degree or third-degree relatives with breast cancer and one or more with ovarian cancer • Presence of a p53 or PTEN mutation • Patients who have received radiation therapy to the chest between the ages of 10 and 30 years <p>II. For women at moderately increased risk of breast cancer for the following medically necessary indications: ¹² Effective 9/1/09.</p> <ul style="list-style-type: none"> • Those who do not meet the definition of high risk, but nonetheless are considered at moderately increased risk based on family history with or without breast lesions associated with an increased risk, including, but not limited to, atypical hyperplasia or breast cancer diagnosed in the opposite breast. For this policy, increased risk is defined as a lifetime risk of breast cancer of 20% or greater as identified by models that are largely defined by family history such as the Gail or Claus model. • Patients with such extensive mammographic abnormalities (i.e., calcifications) that adequate biopsy is impossible <p>III. For patients with lobular carcinoma in situ ¹² Effective 9/1/09</p> <ul style="list-style-type: none"> • To correct sagging breasts⁶
Mastopexy	NO	<ul style="list-style-type: none"> • To correct sagging breasts⁶

	YES	In accordance with the Women’s Health and Cancer Right’s Act of 1998, when performed on affected and unaffected contralateral breast to create symmetry in patients who had undergone a mastectomy, breast conservation therapy (BCT) or other diagnostic procedures causing deformity of the breast in connection with breast cancer, evaluation of breast cancer or suspected breast cancer, or to prevent development of breast cancer in high risk patients. ⁷
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¹ Once implants have been removed, replacing with new implants is only indicated if the original implants were for reconstruction. If the original implants were cosmetic, then new implants are **NOT** covered.

² Only the INITIAL reconstructive repair is covered. If the procedure is normally done in stages with healing periods, then all stages are covered.

⁴ *Effective 1/98 for Medicare HMO Blue and Medicare PPO Blue patients, and 5/1/98 for all other Managed Care plans. Updated 5/99 to apply breast reduction surgery criteria to both males and females.*

⁵ Authorization is required. Patients should have reached puberty (or have reached their 15th birthday), so that initial reconstruction will be more durable. Severe hypoplasia must be demonstrated by photographs, and hypoplastic breast must be no larger than size “A” bra cup. Planned implant size must be at least 200cc. Individual consideration is given for patients who have severe breast asymmetry documented by photographs, but the smaller breast is larger than an “A” cup, if the patient has reached puberty (or have reached their fifteenth birthday) and the planned implant size is over 200 cc.

⁶ Except for Medicare HMO Blue and Medicare PPO Blue members: in accordance with local Medicare policy, this service is covered for Medicare HMO Blue and Medicare PPO Blue patients, when it is not done for cosmetic purposes.

⁷ According to the Women’s Health and Cancer Right’s Act of 1998, BCBSMA offers coverage for women who have undergone a mastectomy and choose to undergo reconstruction in connection with the mastectomy. Federal Law, effective October 21, 1998.

⁸ Based upon expert advice from MSCO (Massachusetts Society of Clinical Oncology) and a study by Lynn Hartmann et al, New England Journal of Medicine volume 340, January 1999, number 2: Efficacy of bilateral prophylactic mastectomy in women with a family history of breast cancer.

⁹ JAMA 2000; 284:319-24. This study described the long-term satisfaction and psychological/social functioning of over 600 women who had bilateral prophylactic mastectomy. Positive outcomes included decreased emotional concern about developing breast cancer and positive psychological and social outcomes. These must be weighed against the negatives, which include the irreversibility of prophylactic mastectomy, and potential problems with reconstructive surgery and implants. Also for some women, there were adverse psychological and social outcomes. Therefore, for each individual the positives must be weighed against the negatives.

¹⁰ <http://www.clinicaltrials.gov/ct/show/NCT00236132>

<http://www.jssm.org/vol4/n3/14/v4n3-14text.php>

<http://www.clinicaltrials.gov/ct/show/NCT00236132>

Williams, A. and Crabbe, D. (2003) Pectus deformities of the anterior chest wall. *Paediatric Respiratory Reviews* 4, 237-242.

¹¹ Based upon expert opinion and recommendation, 3/09.

¹² Based upon BCBSA national policy 7.01.09 Prophylactic Mastectomy issued 12/08. This BCBSA policy was returned to active review and updated with literature search. References 4 and 5 were added. Policy statements were updated with additional high and moderate risk groups.

2008 Update: The policy was returned to active review and was updated using a search of MEDLINE through October 2008. The rationale section of the policy was updated to include additional factors associated with a high rate of cancer including the p53 and PTEN genetic mutations, and patients who received prior radiation therapy to the chest between the ages of 10 and 30 years of age whose risk of breast cancer can be almost 30% by age 55. (4) Many of the published studies identified reported on factors that influenced decisions about

prophylactic mastectomy. A number of studies also discussed both patient satisfaction and quality of life after the procedure.

Professional Guidelines

This updated policy is in agreement with the current National Comprehensive Cancer Network guidelines. (5)

References:

1. 1999 TEC Assessments; Tab 14
2. Hartmann LC, Schaid DJ, Woods JE et al. Efficacy of bilateral prophylactic mastectomy in women with a family history of breast cancer. *N Engl J Med* 1999; 340(2):77-84.
3. Fisher B, Costantino JP, Wickerham DL et al. Tamoxifen for prevention of breast cancer: report of the National Surgical Adjuvant Breast and Bowel Project P-1 Study. *J Natl Cancer Inst* 1998; 90(18):1371-88.
4. Saslow D, Boetes C, Burke W et al. American Cancer Society Guidelines for breast screening with MRI as an adjunct to mammography. *CA Cancer J Clin* 2007; 57(2):75-89. Accessible online at <http://caonline.amcancersoc.org/cgi/eprint/57/2/75> .
5. National Comprehensive Cancer Network. Breast Cancer Risk Reduction. V.1.2008. Accessible at http://www.nccn.org/professionals/physician_gls/PDF/breast_risk.pdf .

Abdomen *	coverage	indications
Diastasis recti repair	NO	To repair separation of abdominal muscles.
Lipectomy, Liposuction	NO	Surgery to remove fat. When the purpose is removal of fat for cosmetic reasons, this surgery is not covered.
Panniculectomy or Abdominoplasty	YES	After significant weight loss, in patients with stable weight, for any of the following: ¹ (effective 4/1/00). We cover the initial panniculectomy. <ul style="list-style-type: none"> • Recurrent documented rashes or non healing ulcers • When there is a functional impairment, such as significant difficulty with walking. Prior authorization and documentation are required
	NO	For panniculectomy or abdominoplasty, with or without diastasis recti repair, for the treatment of back pain ⁴ For abdominoplasty when done to remove excess skin or fat with or without tightening of the underlying muscles ⁴

* See General Policy Statement.

Muscles, Bone *	coverage	indications
Musculoskeletal transplants ²	YES	<ul style="list-style-type: none"> • Initial repair after accidental injury ^{1,2} OR • To restore bodily function or correct a functional impairment caused by: an accidental injury³; a birth defect¹; or a prior surgical procedure or disease.³
	NO	For cosmetic procedures to improve appearance, including repeat operations to alter appearance, not function.

¹ Only the INITIAL **reconstructive** repair is covered. If the procedure is normally done in stages with healing periods, then all stages are covered.

² Requires individual consideration and prior authorization.

³ See subscriber certificate

⁴ Expert opinion

* See General Policy Statement

Individual consideration (Clinical Exceptions)

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. For consideration of an individual patient, physicians may send relevant clinical information to:

For services already billed

Blue Cross Blue Shield of Massachusetts
Provider Appeals
PO Box 986065
Boston, MA 02298

Prior to performance of service

Blue Cross Blue Shield of Massachusetts
Case Creation/Medical Policy
One Enterprise Drive
Quincy, MA 02171
Tel: 1-800-327-6716
Fax: 1-888-282-0780

Managed care guidelines

- **For Medicare HMO Blue members:** Referrals are required for all visits to a specialist. Authorizations are required for blepharoplasty, rhinoplasty, septoplasty when combined with rhinoplasty, and maxillofacial surgery.
- **For HMO Blue members:** All visits to a specialist, except OB/GYN specialists, require a referral. Authorizations are required. Authorizations are not required for septoplasty.
- Authorizations are not required for wigs, for laser treatments for treatment of port wine stains/hemangiomas on the face and neck, or for Pulsed Dye Laser treatments for hypertrophic scars.

Indemnity and PPO guidelines

All authorization requirements are determined by the individual's subscriber certificate, however:

- Authorizations are required for all inpatient services
- Authorizations are not required for most outpatient services as determined by the individual's subscriber certificate
- Referrals to a specialist are not required.

Authorizations are not required for wigs or for laser treatments for treatment of port wine stains/hemangiomas on the face and neck.

Coding information

Procedure codes are from current CPT, HCPCS Level II, Revenue Code, and/or ICD-9-CM manuals, as recommended by the American Medical Association, Centers for Medicare and Medicaid Services and American Hospital Associations. Blue Cross Blue Shield Association national codes may be developed when appropriate.

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

I. HEAD AND HAIR PROCEDURES:

Hair Transplant Procedures:

- CPT code 15220, full thickness graft; free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less

- CPT code 15221, full thickness graft; free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm (List separately in addition to code for primary procedure)
- CPT code 15775, punch graft for hair transplant; 1 to 15 punch grafts
- CPT code 15776, punch graft for hair transplant; more than 15 punch grafts

Wig:

- HCPCS Level II code A9282, wig, any type, each

NOTE: Wigs are covered according to the individual contract, under the prosthetic benefit. For more information concerning wigs, refer to document # 367.

II. SKIN PROCEDURES:

Medically Necessary Benign Lesion/Skin Tag Excision/Destruction Codes:

Removal of Skin Tags:

- CPT code 11200, removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
- CPT code 11201, removal of skin tags, multiple fibrocutaneous tags, any area; each additional ten lesions (List separately in addition to code for primary procedure)

Shaving of Epidermal or Dermal Lesions:

- CPT code 11300, shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less
- CPT code 11301, shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm
- CPT code 11302, shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm
- CPT code 11303, shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm
- CPT code 11305, shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands feet, genitalia; lesion diameter 0.5 cm or less
- CPT code 11306, shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands feet, genitalia; lesion diameter 0.6 to 1.0 cm
- CPT code 11307, shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands feet, genitalia; lesion diameter 1.1 to 2.0 cm
- CPT code 11308, shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands feet, genitalia; lesion diameter over 2.0 cm
- CPT code 11310, shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose lips, mucous membrane; lesion diameter 0.5 cm or less
- CPT code 11311, shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose lips, mucous membrane; lesion diameter 0.6 to 1.0 cm
- CPT code 11312, shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose lips, mucous membrane; lesion diameter 1.1 to 2.0 cm
- CPT code 11313, shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose lips, mucous membrane; lesion diameter over 2.0 cm

Excision of Benign Lesions:

- CPT code 11400, excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
- CPT code 11401, excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm

- CPT code 11402, excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm
- CPT code 11403, excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3 cm
- CPT code 11404, excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm
- CPT code 11406, excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4 cm
- CPT code 11420, excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
- CPT code 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
- CPT code 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
- CPT code 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
- CPT code 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
- CPT code 11426, excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
- CPT code 11440, excision, benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
- CPT code 11441, excision, 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
- CPT code 11442, excision, 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
- CPT code 11443, excision, benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm
- CPT code 11444, excision, 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
- CPT code 11446, excision, benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm

Destruction, Benign or Premalignant Lesions:

- CPT code 17000, destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); first lesion
- CPT code 17003, destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)
- CPT code 17004, destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); 15 or more lesions (Do not report 17004 in conjunction with 17000-17003)
- CPT code 17110, destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; up to 14 lesions
- CPT code 17111 destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; 15 or more lesions

NOTE: The above codes will deny, leaving no patient balance, if submitted with a diagnosis of rosacea. (*Effective 9/07*). See footnote 13 for rationale under Skin section in the body of this policy.

Port Wine Stains/Deforming Hemangioma Treatment:

- CPT code 17106, destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm
- CPT code 17107, destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq cm
- CPT code 17108, destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq cm

NOTE: Prior authorization is not required for laser treatment codes--- CPT code range 17106-17108.

Hypertrophic Scar treatment:

- CPT code 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
- CPT code 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

NOTE: Prior authorization is not required for laser treatment codes – CPT codes 17110 and 17111.

Dermatologic Treatment with Photodynamic Therapy:

- CPT code 96567, photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (e.g., lip) by activation of photosensitive drug(s), each phototherapy exposure session
- HCPCS Level II code J7308, aminolevulinic acid HCL for topical administration, 20%, single unit dosage form (354mg)
- HCPCS Level II code J7309, Methyl Aminolevulinate (MAL) for topical administration, 16.8%, 1 Gram

NOTE: For coding information regarding PUVA, see Medical Policy #059.

III. EYE PROCEDURES:

Blepharoplasty Procedures:

- CPT code 15821, blepharoplasty, lower eyelid;
- CPT code 15821, blepharoplasty, lower eyelid; with extensive herniated fat pad
- CPT code 15822, blepharoplasty, upper eyelid;
- CPT code 15823, blepharoplasty, upper eyelid; with excessive skin weighting down lid

Brow Ptosis Procedures:

- CPT code 67900, repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
- CPT code 67901, repair of blepharoptosis; frontalis muscle technique with suture or other material (e.g., banked fascia)
- CPT code 67902, repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
- CPT code 67903, repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
- CPT code 67904, repair of blepharoptosis; (tarso) levator resection or advancement, external approach
- CPT code 67906, repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
- CPT code 67908, repair of blepharoptosis; conjunctivo-tarso-Muller’s muscle-levator resection (e.g., Fasanella-Servat type)

IV. NOSE PROCEDURES:

Rhinoplasty Procedures:

- CPT code 30400, rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
- CPT code 30410, rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
- CPT code 30420, rhinoplasty, primary; including major septal repair
- CPT code 30430, rhinoplasty, secondary; minor revision (small amount of nasal tip work)
- CPT code 30435, rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
- CPT code 30450, rhinoplasty, secondary; major revision (nasal tip work and osteotomies)

Excision or surgical planing of nose for rhinophyma:

- CPT code 30120, excision or surgical planing of skin of nose for rhinophyma

NOTE: CPT code 30120 will deny if submitted with a diagnosis other than rhinophyma (ICD-9 CM diagnosis 695.3), leaving no patient balance.

Septoplasty Procedures:

- CPT code 30520, septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft.
- CPT code 30620, septal or other intranasal dermatoplasty (does not include obtaining graft)
- CPT code 30630, repair nasal septal perforations

NOTE: Prior authorization is required for septoplasty procedures submitted with CPT codes 30620 and 30630 for our Medicare HMO Blue and Medicare PPO Blue members only.

V. FACE, EARS, CHEEK, MOUTH, JAW PROCEDURES:**Surgical procedures performed to correct cleft lip/palate congenital deformities:**

- CPT code 40510, excision of lip; transverse wedge excision with primary closure
- CPT code 40520, excision of lip; V-excision with primary direct linear closure
- CPT code 40525, excision of lip; full thickness, reconstruction with local flap (e.g., Estlander or fan)
- CPT code 40527 excision of lip; full thickness, reconstruction with cross lip flap (e.g., Abbe-Estlander)
- CPT code 40530, resection of lip, more than one-fourth, without reconstruction
- CPT code 40650, repair lip; full thickness; vermilion only
- CPT code 40652, repair lip; up to half vertical height
- CPT code 40654, repair lip; over one-half vertical height or complex
- CPT code 40700, plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral
- CPT code 40701, plastic repair of cleft lip/nasal deformity; primary, bilateral, one stage procedure
- CPT code 40702, plastic repair of cleft lip/nasal deformity; primary, bilateral, one of two stages
- CPT code 40720, plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure
- CPT code 40761, plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle
- CPT code 42200, palatoplasty for cleft palate, soft and/or hard palate only
- CPT code 42205, palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only
- CPT code 42210, palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)
- CPT code 42215, palatoplasty for cleft palate; major revision
- CPT code 42220, palatoplasty for cleft palate; secondary lengthening procedure
- CPT code 42225, palatoplasty for cleft palate; attachment pharyngeal flap

Mandibular or Maxillary Osteotomy/Osteoplasty for prognathism or micrognathism with documented severe handicapping malocclusion:

- CPT code 21193, reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
- CPT code 21194, reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)
- CPT code 21195, reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
- CPT code 21196, reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
- CPT code 21198, osteotomy, mandible, segmental;
- CPT code 21199, osteotomy, mandible, segmental; with genioglossus advancement
- CPT code 21206, osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)

VI. BREAST PROCEDURES:

Mastectomy Procedures:

- CPT code 19300, mastectomy for gynecomastia

NOTE: CPT code 19300 rejects as cosmetic, leaving a patient balance.

- CPT code 19301, mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy);
- CPT code 19302, mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
- CPT code 19303, mastectomy, simple, complete
- CPT code 19304, mastectomy, subcutaneous
- CPT code 19305, mastectomy, radical including pectoral muscles, axillary lymph nodes
- CPT code 19306, mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)
- CPT code 19307, mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle

Breast Repair and/ or Mammoplasty Procedures:

- CPT code 19316, mastopexy
- CPT code 19318, reduction mammoplasty
- CPT code 19324, mammoplasty, augmentation; without prosthetic implant
- CPT code 19325, mammoplasty augmentation with prosthetic implant.
- CPT code 19328, removal of intact mammary implant.
- CPT code 19330, removal of mammary implant material.

Breast Reconstruction Procedures:

- CPT codes 19340 - 19350 and 19357 - 19369 report surgical procedures to restore the breast to normal appearance after covered mastectomy surgery and surgical procedures performed on the contralateral unaffected breast for symmetry.

CPT codes 19340-19350:

- CPT code 19340, immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
- CPT code 19342, delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
- CPT code 19350, nipple/areola reconstruction

CPT codes 19357-15369:

- CPT code 19357, breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
- CPT code 19361, breast reconstruction with latissimus dorsi flap; without prosthetic implant
- CPT code 19364, breast reconstruction with free flap
- CPT code 19366, breast reconstruction with other technique
- CPT code 19367, breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site:
- CPT code 19368, breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site: with microvascular anastomosis (supercharging)
- CPT code 19369, breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site.

National codes S2066-S2068 report breast reconstruction procedures that may be used to restore the breast to normal appearance after mastectomy, breast conservation therapy (BCT), or other diagnostic procedures causing deformity of the breast in connection with breast cancer, evaluation of breast cancer or suspected breast cancer, or to prevent development of breast cancer in high risk patients.

Additional Breast Reconstruction Procedures:

- National code S2068, breast reconstruction with deep inferior epigastric perforator (DIEP) flap or superficial inferior epigastric artery (SIEA) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral
- National code S2066, breast reconstruction with gluteal artery perforator (GAP) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral
- National code S2067, breast reconstruction of a single breast with “stacked” deep inferior epigastric perforator (DIEP) flap(s) and/or gluteal artery perforator (GAP) flap(s), including harvesting of the flap(s), microvascular transfer, closure of donor site(s) and shaping the flap into a breast, unilateral

CPT codes 19370-19396 report breast reconstruction procedures that may be used to restore the breast to normal appearance after mastectomy, breast conservation therapy (BCT), or other diagnostic procedures causing deformity of the breast in connection with breast cancer, evaluation of breast cancer or suspected breast cancer, or to prevent development of breast cancer in high risk patients.

CPT codes 19370-19396:

- CPT code 19370, open periprosthetic capsulotomy, breast
- CPT code 19371, periprosthetic capsulotomy, breast
- CPT code 19380, revision of reconstructed breast
- CPT code 19396, preparation of moulage for custom breast implant

Congenital Chest Wall Deformity:

- CPT code 21740, reconstructive repair of pectus excavatum or carinatum; open
- CPT code 21742, reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thorascopy.
- CPT code 21743, reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thorascopy.

VII. MUSCLE/BONE PROCEDURES:

- Use appropriate CPT code that best represents musculoskeletal transplants.

VIII. CONGENITAL DEFORMITIES IN CHILDREN:

Surgical Procedures to correct syndactyly:

- CPT code 26560, repair of syndactyly (web finger) each web space; with skin flaps
- CPT code 26561, repair of syndactyly (web finger) each web space; with skin flaps and grafts
- CPT code 26562, repair of syndactyly (web finger) each web space; complex (e.g., involving bone, nails)

Repair macrodactyilia:

- CPT code 26590, repair macrodactyilia, each digit

IX. COSMETIC PROCEDURES THAT WILL REJECT IF THE COVERAGE GUIDELINES IN THE MEDICAL POLICY ARE NOT MET:

Dermabrasion, CPT codes 15780-15783

- CPT code 15780, dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
- CPT code 15781, dermabrasion; segmental, face
- CPT code 15782, dermabrasion; regional, other than face
- CPT code 15783, dermabrasion; superficial, any site (e.g., tattoo removal)

NOTE: The above codes will deny, leaving no patient balance, if submitted with a diagnosis of rosacea *(Effective 9/07)*. See footnote 13 for rationale under Skin section in the body of this policy.

Abdominoplasty Procedures, CPT codes 15830-15831:

- CPT code 15830, excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
- CPT code 15847, excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen (eg, abdominoplasty) (including umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)

Intralesional Injection, CPT codes 11900-11901:

- CPT code 11900, injection, intralesional; up to and including seven lesions
- CPT code 11901, injection, intralesional; more than seven lesions

NOTE: CPT codes 11900 and 11901 may be appropriate to report injection of painful acne cysts

Chemical Peel Procedures:

- CPT code 15788, chemical peel, facial; epidermal (*Medicare HMO Blue and Medicare PPO Blue members only*)
- CPT code 15789, chemical peel, facial; dermal (*Medicare HMO Blue and Medicare PPO Blue members only*)

Inverted Nipple Correction:

- CPT code 19355, correction of inverted nipples
 1. Payable if determined not to be cosmetic for Medicare HMO Blue and Medicare PPO Blue members.
 2. Covered when a breast reconstruction procedure is performed to restore the breast to normal appearance after mastectomy, breast conservation therapy (BCT), or other diagnostic procedures causing deformity of the breast in connection with breast cancer, evaluation of breast cancer or suspected breast cancer, or to prevent development of breast cancer in high risk patients.

X. COSMETIC PROCEDURES THAT WILL REJECT AS COSMETIC, LEAVING A PATIENT BALANCE:

Subcutaneous injection of filling material, CPT codes 11950-11954:

- CPT code 11950, subcutaneous injection of filling material (e.g., collagen); 1 cc or less
- CPT code 11951, subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
- CPT code 11952, subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
- CPT code 11954, subcutaneous injection of filling material (e.g., collagen); over 10.0 cc

Excision of excessive skin, CPT codes 15832-15839:

- CPT code 15832, excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
- CPT code 15833, excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
- CPT code 15834, excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
- CPT code 15835, excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
- CPT code 15836, excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
- CPT code 15837, excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
- CPT code 15838, excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
- CPT code 15839, excision, excessive skin and subcutaneous tissue (includes lipectomy); other area

Lipectomy, Liposuction or Abdominoplasty, CPT codes 15876-15879:

- CPT code 15876, suction assisted lipectomy; head and neck
- CPT code 15877, suction assisted lipectomy; trunk
- CPT code 15878, suction assisted lipectomy; upper extremity
- CPT code 15879, suction assisted lipectomy; lower extremity

Electrolysis, CPT code 17380:

- CPT code 17380, electrolysis epilation, each 30 minutes

Chemical Peel Procedures, CPT codes 15788-15793:

- CPT code 15788, chemical peel, facial; epidermal*
- CPT code 15789, chemical peel, facial; dermal*
- CPT code 15792, chemical peel, nonfacial; epidermal*
- CPT code 15793, chemical peel, nonfacial; dermal*

Rhytidectomy, CPT codes 15824-15829:

- CPT code 15824, rhytidectomy; forehead
- CPT code 15825, rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
- CPT code 15826, rhytidectomy; glabellar frown lines
- CPT code 15828, rhytidectomy; cheek, chin and neck
- CPT code 15829, rhytidectomy; superficial musculoaponeurotic system (SMAS) flap

Blepharoplasty, CPT codes 15820-15821:

- CPT code 15820, blepharoplasty, lower eyelid;
- CPT code 15821, blepharoplasty, lower eyelid; with extensive herniated fat pad

Gynecomastia, CPT code 19140, 19300:

- CPT code 19300, mastectomy for gynecomastia

Otoplasty, CPT code 69300:

- CPT code 69300, otoplasty, protruding ear, with or without size reduction

Genioplasty Surgical Procedures, CPT codes 21120-21123:

- CPT code 21120, genioplasty; augmentation (autograft, allograft, prosthetic material)*
- CPT code 21121, genioplasty; sliding osteotomy, single piece*
- CPT code 21122, genioplasty; sliding osteotomies, two or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)*
- CPT code 21123, genioplasty, sliding, augmentation with interpositional bone grafts (includes obtaining autografts)*

*** NOTE: Except for Medicare HMO Blue and Medicare PPO Blue, reimbursable if determined not to be cosmetic.**

Other information

- For our Medical Technology Assessment Guidelines, see document #[350](#).

Laser Surgery: We recommend medically necessary accepted new laser procedures, and substantially equivalent laser procedures when the following guidelines are met:

- The hospital in which the laser procedure is to be performed must have a formal program in laser safety. Minimum program requirements include:
 - A laser safety committee or other appropriate committee to approve indications for specific laser procedures, to approve standard operating practices, and to credential physicians and ancillary staff who will be involved with the use of laser.
 - A laser safety officer to select appropriate protective equipment, inspect and evaluate laser systems, review standard operating practices, and monitor laser use in the facility.
- If the procedure is performed outside of a hospital, the facility must demonstrate continuous safety certification by a regulatory body comparable to a hospital laser safety committee and recognized by BCBSMA.
- The provider performing the laser procedure must hold proper credentials to perform that procedure, granted by a hospital laser safety committee or comparable regulatory body recognized by BCBSMA.
- The provider performing the laser procedure must obtain a tissue specimen for independent pathological review, the findings of which must be entered into the patient's record. When a tissue specimen is unobtainable, acceptable pre-operative and post-operative photographs or other recording must be entered into the patient's record.

We do not recommend experimental/ investigational laser procedures.

- Bill for the laser procedure with the existing CPT code, which is equivalent to the surgical procedure in which the laser substitutes for the traditional surgical instrument.
- No separate or additional allowance is provided for the laser itself.

Laser (acronym for Light Amplification by Stimulated Emission of Radiation) is an instrument for producing orderly beams of intense light of one color, which can be concentrated to produce either cut, burn, or seal off tissue. Laser procedures are classified into 3 categories:

Substantially Equivalent Laser procedures: are generally accepted surgical procedures in which the laser merely serves as a substitute for the traditional surgical instrument (such as a scalpel knife). In order to qualify as substantially equivalent, a laser procedure must fulfill the following:

- The procedure has been previously found by BCBSMA to meet our medical technology assessment guidelines, when performed with conventional instruments.

- Demonstration that at least one model of the generic laser type (CO₂, Argon, Nd: YAG, etc.) has received full FDA approval for use in either the procedure involved, or its relevant anatomic region.
- Acceptable evidence that the use of the laser does not alter the risk or efficacy of the procedure to the extent that it would not meet our medical technology assessment guidelines.
- Acceptable evidence that the use of the laser maintains or increases the quality of patient care associated with the procedure and lowers or maintains the total patient-care cost (such as length of stay, follow-up problems, and need for repeat procedure) compared to the standard procedure.

Generally Accepted New Laser Procedures: Laser procedures for which there is no equivalent, conventional, surgical approach, but which has been determined by BCBMSA (through assignment of specific laser procedure codes and allowances) to meet our technology assessment guidelines.

Experimental/ Investigative Laser Procedures: Laser procedures which do not meet the above guidelines. Experimental/ investigative laser procedures usually fall into one of the following categories:

- No model of the generic laser type used in the procedure has received full FDA approval.
- Procedures that do not meet our medical technology assessment guidelines, regardless of type of instrument used.
- Even though a laser device may have received FDA approval, if the procedure does not meet our Medical Technology Assessment Guidelines, #350, the laser procedure would be non covered.

Policy update history

See contract statements for explanation of contractual exclusions.

Issued 11/95 based on the Medical Policy Group discussion of reasonable medical necessity for plastic surgical procedures. Musculoskeletal section added 9/96. Reviewed 12/96 to add wigs information, without change in policy. Updated 6/97 to add indemnity guidelines. Updated 10/97 to add coverage for breast implant removal for capsular contracture or pain, abdominoplasty for chronic non-healing abdominal ulcers; and restoration mammoplasty after mastectomy for fibrocystic disease, and reconstruction of the unaffected breast following mastectomy for cancer was added. Special thanks to Dr. LoVerme, President of Massachusetts Society of Plastic Surgery. Updated 3/98 to exclude coverage for gynecomastia in males, and to include coverage for panniculectomy when required to correct a specific current functional impairment, and remove requirement for airway obstruction for reconstructive rhinoplasty after injury. Updated 4/98 to include specific height-weight and minimum estimated breast tissue removal for reduction mammoplasty. Updated 5/98 to include coverage for benign lesions when medically necessary, i.e., bleeding, pain, recent change in color or enlargement, exposed to frequent irritation; effective 10/1/98. Updated 6/98; included coverage for augmentation mammoplasty performed on unaffected contralateral breast when performed during the same operative session; effective 6/98. Surgery on contralateral breast is a once in a lifetime benefit only. Updated 7/98; included coverage for restoration after mastectomy on unaffected contralateral breast when performed during the same operative session; effective 6/98. Surgery on contralateral breast is a once in a lifetime benefit only. Updated 8/98 to clarify member certificate language on restorative surgery. Updated 11/98 to include federal mandate on breast reconstruction after mastectomy and to add coverage for severe microtia. Updated 1/99 to exclude coverage for dynamic orthotic cranioplasty. Updated 2/99 to clarify coverage for laser treatment of port wine stains, and to add coverage for vitiligo treatment of the face and neck, effective 3/1/99 (see policy #59 for details). Special thanks to the Massachusetts Chapter of the American Academy of Dermatology and Dr. Joop Grevelink of Massachusetts General Hospital. Billing information was also included for collagen injections. Updated 5/99 to apply breast reduction surgery criteria to both males and females, and to mention contractual exclusions for sex reassignment surgery. Updated 6/99 to exclude coverage for Botulinum Toxin when used for cosmetic reasons. Updated 7/99 to include coverage for mastopexy when performed on unaffected contralateral breast to create symmetry, in accordance with the 1998 Women's Health and Cancer Act. Updated 8/99 to include billing information for augmentation mammoplasty in compliance with the 1998 Women's Health and Cancer Act. Updated 10/99 to include coverage for laser blepharoplasty and prophylactic breast mastectomy for women at higher or normal risk for breast cancer. Updated 2/00 to include repair of

brow ptosis for visual impairment- thanks to Dr. Elliot Lach, EBR 2/00. And to include coverage for intralesional injection of acne cysts, effective 4/1/00. Coverage for panniculectomy for documented recurrent ulcers or rashes unresponsive to conventional treatment, or functional impairment such as difficulty walking added 4/00 based on Medical Policy Group discussions with Dr. Kristin Stueber 12/99. Excluded coverage for hair removal by any method including laser or electrolysis. Updated 4/00 to include the revised subscriber contract definition of reconstructive surgery according to rider 99-804 and recommendations from the Benefit Administration Committee, issued 3/1/00; effective 7/1/00. Prior to 7/1/00, reconstructive surgery was defined as follows: "A procedure to improve or restore bodily function, or to correct a functional impairment caused by: an accidental injury; a birth defect; or a prior surgical procedure or disease. The injury must have occurred on or after the effective date of the member's BCBS coverage, and only the INITIAL restorative repair is covered. If the procedure is normally done in stages with healing periods, then all stages are covered." Updated 9/00 to clarify coverage exclusion for removal or application or treatment of decorative or self-inflicted tattoos. Updated 1/01 to include coverage for hair removal if ingrown hairs are responsible for repeated painful cysts; PUVA for vitiligo on the hands; gynecomastia in Klinefelter's syndrome; and Romberg's disease in patients with severe facial deformity. Updated 7/01 to clarify coverage for initial panniculectomy or abdominoplasty. Updated 9/01 to include coverage for photodynamic therapy for actinic keratoses for Blue Care 65 members, effective 7/19/01. Updated 5/03 to clarify coverage for tattooing of the areola as part of a nipple reconstruction following a covered mastectomy. Updated 6/03 to clarify that when CPT codes 75894 or 75896 is billed with S2130; reimbursement of these codes is included in S2130 allowance. Updated 8/03 to include coverage for dynamic orthotic cranioplasty effective immediately. Reviewed 9/03 MPG hematology/oncology, no changes in coverage were made. Updated 10/03 to include coverage for photodynamic therapy for actinic keratoses, effective January 2004. Updated 10/03 to remove coverage reference to dynamic orthotic cranioplasty because an administrative decision was made to allow coverage, when billed under the appropriate code. Reviewed 10/03 MPG ob/gyn and infertility, no changes in coverage were made. Reviewed 11/03 MPG pediatrics, no changes in coverage were made. Reviewed 12/03 MPG plastic surgery and dermatology, no changes in coverage were made. Updated 4/04 to remove prior authorization for laser treatments for port wine stains/hemangiomas. Reviewed 5/04 MPG pediatrics, no changes in coverage were made. Updated 9/04 to clarify coverage for endoscopic transthoracic sympathectomy for the treatment of primary hyperhidrosis. Reviewed 9/04 MPG hematology/oncology, no changes in coverage were made. Updated 10/04 MPG obstetrics and gynecology, no changes in coverage were made. Updated 12/04 MPG - plastic surgery and dermatology. The following clarifications were made:

- Augmentation mammoplasty: Surgery on either contralateral breast is a once in a lifetime benefit only
- Lipectomy/liposuction: When the purpose is removal of fat for cosmetic reasons, this surgery is not covered. Also, clarified that orthodontics are not covered under the medical plan. Updated 2/05 to clarify coverage exclusion of iontophoresis and axillary liposuction for treatment of primary hyperhidrosis. Updated 2/05 to include revisions of National policy 2.01.44 Photodynamic Therapy for the Treatment of Actinic Keratoses and Other Skin Lesions. Policy statement updated to include coverage exclusion for Metvix[®] therapy and coverage exclusion for photodynamic therapy as a technique of skin rejuvenation, hair removal, or other cosmetic indications. Updated 2/05 to clarify coverage exclusion of tunable dye laser treatments of pyogenic granulomas. Reviewed 5/05 MPG Pediatrics, no changes in coverage were made. Reviewed 6/05 Blue Cross Blue Shield Association National policy 2.01.44 issued 4/05, added references as well as policy statement on Metvix[®] therapy changed to include coverage for non hyperkeratotic actinic keratoses of the face and scalp. Effective 11/05. Updated 6/05 to clarify coverage exclusion of photodynamic therapy with methyl aminolevulinate and exposure to red light for the treatment of other dermatologic applications, including but not limited to acne vulgaris and mycoses. Effective 11/05. Updated 6/05 to clarify coverage exclusion of photodynamic therapy with topical ALA and exposure to blue or red light for other dermatologic applications, including, but not limited, acne vulgaris, hidradenitis suppurativa, and mycoses. Effective 11/05. Reviewed 9/05 MPG Hematology/Oncology, no changes in coverage were made. Updated 7/05 to exclude coverage for non-pharmacologic treatment of rosacea, including but not limited to laser and light therapy, dermabrasion, chemical peels, surgical debulking and electrosurgery; effective 7/1/2005. Updated 9/05 to clarify coverage statement on complications from a non-covered cosmetic service. Reviewed 10/05 MPG Obstetrics/Gynecology, no changes in coverage were made. Updated 12/05 to clarify Breast Reduction Surgery guidelines (gynecomastia reconstruction and reduction mammoplasty), effective February 2006.

Updated 12/05 to clarify coverage guidelines on pectus excavatum to include the Haller index, effective 2/06; and to clarify the guideline on Port Wine Stain laser treatments. Updated 1/06 to clarify coverage for breast reconstruction after mastectomy and breast conservation therapy. Both definitions were added. Effective January 2006. Updated 2/06 after review of BCBSA national policy addressing sclerotherapy, added rationale and references. Reviewed 5/06 MPG-Pediatrics, no changes in coverage were made. Updated 6/06 after review of BCBSA national policy addressing non pharmacologic treatment of rosacea with additional reference added. Updated 6/06 with CPT codes reporting chemodestruction effective 1/1/06. Reviewed 9/06 MPG-Hematology/Oncology, no changes in coverage were made. Updated 10/06 based on review of 2006 BCBSA national policy addressing PDT for treatment of Actinic Keratoses and Other Skin Lesions, added reference, no change in policy statement. Reviewed 10/06 MPG – Obstetrics and Gynecology, no changes in coverage were made. Updated 12/06 Billing, now Coding Information section, and added new and deleted 1/1/07 CPT codes. Reviewed 12/06 MPG- Plastic Surgery and Dermatology, no changes in coverage were made. Updated 1/07 to clarify coverage of inverted nipples, breast reconstruction procedures and mastopexy procedures performed to restore the breast(s) to normal appearance after mastectomy, breast conservation therapy (BCT) or other diagnostic procedures causing deformity of the breast. Updated 3/07 to clarify coverage exclusion of laser hair removal of pilonidal cysts if ingrown hairs are responsible for repeated painful cysts. Updated 3/07 after review of BCBSA policy addressing non pharmacologic treatment of rosacea issued 12/06 without change in coverage exclusion, additional 3 references added under footnote 13. Updated 6/07 to expand coverage for initial panniculectomy or abdominoplasty after significant weight loss to state recurrent documented rashes or non healing ulcers, (removed *that do not respond to conventional treatment*), based upon proposal from Consumer Affairs and approval of Medical Director, effective 7/1/07. Updated 6/07 to add new National S codes effective 7/1/07 that report breast reconstruction procedures; clarified examples of women at higher than normal risk for breast cancer for prophylactic mastectomy to include patients with a known BRCA1 or BRCA2 mutation as well as patients with a BRCA1 or BRCA2 mutation in a family member with breast or ovarian cancer. Updated 8/07 after review of BCBSA policy 2.01.69, addressing laser treatment of active acne issued 4/07, without change in coverage exclusion; added footnote 16 under Skin Section of this policy to incorporate rationale and references. The non coverage of laser treatment of active acne is also noted on #400 with non covered effective date of 4/2006. Updated 8/07 to implement editing to support coverage exclusion of non pharmacologic treatment of rosacea, effective 9/1/07. Updated 8/07 Managed care guidelines to clarify that authorizations are not required for septoplasty procedures for HMO Blue members and clarified prior authorization is required for septoplasty procedures submitted with CPT codes 30620 and 30630 for our Medicare Advantage Plan members only. Reviewed 9/07 MPG Hematology/Oncology, no changes in coverage were made. Updated 11/07 to remove coverage and non coverage statements related to varicose vein treatments, as well as references, policy update history and coding information. Varicose Vein Treatments is separately addressed under Medical Policy #045, new policy effective 12/1/07. Reviewed 10/07 MPG – Obstetrics and Gynecology, no changes in coverage were made. Reviewed 12/07 MPG- Plastic Surgery and Dermatology, no changes in coverage were made. Updated 2/08 to clarify coverage language specific to implant repositioning and congenital chest wall deformity, as well as information specific to FDA approval of laser devices. Updated 2/08 to clarify coverage of Allograft material use in breast reconstruction procedures performed to restore the breast(s) to normal appearance after mastectomy, breast conservation therapy (BCT) or other diagnostic procedures causing deformity of the breast. Updated 4/08 to clarify under Managed Care guideline section and Indemnity and PPO guideline section, authorizations are not required for laser treatments for treatment of port wine stains/hemangiomas on the face and neck. Updated 4/08 after review of BCBSA policy issued 2/08 without change in policy statements related to hyperhidrosis treatments; added rationale and 4 additional references under footnote 11. Reviewed 5/08 MPG-Pediatrics, no changes in coverage were made. Updated 6/08 to clarify coverage of excision and/or shaving of rhinophyma using a laser or other technique when there is documented evidence of bleeding, infection, or functional airway obstruction; removed language specific to prior authorization is not required for children under age 13 with a diagnosis of cleft lip for surgical procedures to correct cleft lip/palate congenital deformities. Updated 8/08 after review of BCBSA policy Dermatologic Applications of Photodynamic Therapy issued 8/07, added coverage of PDT for superficial basal cell skin cancer and for Bowen’s disease (squamous cell carcinoma in situ) only when surgery and radiation are contraindicated, effective 9/1/08; aligned our policy statements with BCBSA national policy and removed references to topical ALA with exposure to blue light as well as methyl aminolevulinate with exposure to red

light, added rationale and references 14-21 under footnote 14 under Skin Section. Updated 8/08 after review of BCBSA policy issued 6/08 addressing laser treatment of active acne without change in coverage exclusion, added rationale and additional reference under footnote 16 under Skin Section. Updated 8/08 to clarify coverage for cleft lip and palate surgery when congenital defects are severe and debilitating as well as clarified for this surgery, prior authorization is required. Reviewed 10/08 MPG-obstetrics/gynecology, no changes in coverage were made. Updated 11/08 to clarify subscriber certificate definition of reconstructive surgery. Updated 11/08 after review of BCBSA policy issued 8/08 addressing dermatologic applications of photodynamic therapy without change in coverage statements, added additional references under footnote 14 under Skin Section. Updated 11/08 to clarify cleft lip and/or palate coverage. Reviewed 12/08 MPG-Plastic Surgery and Dermatology, no changes in coverage were made. Updated 1/09 to remove reference to iontophoresis for treatment of primary hyperhidrosis as it is now separately addressed under policy, #095 Iontophoresis. Updated 2/09 to remove prior authorization language, coverage and coding information specific to abdominal hernias. Updated 4/09 to add definition of puberty and to clarify non coverage of reduction mammoplasty (breast reduction surgery) in pubertal females. Reviewed 5/09 MPG-Pediatrics, no changes in coverage were made. Updated 8/09 after review of BCBSA national policy Prophylactic Mastectomy issued 12/08; added coverage of prophylactic mastectomy for patients at high risk of breast cancer, for patients who are at moderately increased risk of breast cancer and for patients with lobular carcinoma in situ; coverage is effective 9/1/09 for commercial products and for Medicare HMO Blue, Medicare PPO Blue and Blue Medicare PFFS PlusRx. Updated 8/09 Coding Information section to remove 2007 deleted CPT codes (19140, 19160, 19162, 19180, 19182, 19200, 19220, 19240 and 15831) and deleted 2006 HCPCS Level II code S8095; removed definition section. Reviewed 9/2009 MPG-Hematology and Oncology, no changes in coverage were made. Reviewed 10/2009 MPG-Obstetrics and Gynecology, no changes in coverage were made. Updated 11/09 to remove coverage and non coverage statements related to treatment of hyperhidrosis, including endoscopic transthoracic sympathectomy, surgical excision of axillary sweat glands and axillary liposuction. Updated 11/09 to remove hyperhidrosis references noted under footnote 11, and coding information section. Treatment of Hyperhidrosis is now separately addressed under Medical Policy #144, effective 12/1/09. Updated 12/09 to clarify coverage of physical complications related to staged mastectomy for breast reconstruction. Reviewed 12/2009 MPG Plastic Surgery and Dermatology, no changes in coverage were made. Updated 3/10 after review of BCBSA policy issued 12/09 addressing non-pharmacologic treatment of rosacea without change in coverage exclusion; added rationale and references under footnote 13 noted under Skin Section. Updated 4/10 after review of BCBSA policy Dermatologic Applications of Photodynamic Therapy issued 1/10, without change in policy statements; added references 24-29 under footnote 14 noted under Skin Section. Updated 5/10 to clarify coverage of excess skin removal when there is documentation of functional impairment or recurrent documented rashes or non-healing ulcers and to clarify coverage exclusion of laser hair removal as a treatment of a pilonidal cyst. Reviewed 5/2010 MPG-Pediatrics, no changes in coverage were made. Reviewed 9/2010 MPG-Hematology and Oncology, no changes in coverage were made. Reviewed 10/2010 MPG Obstetrics and Gynecology, no changes in coverage were made. Updated 12/2010 to add the new HCPCS Code J7309 effective 1/1/2011. Updated 1/1/2011: 1) to add coverage of pulsed dye laser treatment of hypertrophic scars when there is documented functional impairment, effective 1/1/11; and 2) to remove claims systems editing that addresses coverage of port wine stain laser treatments (tunable dye laser) billed with CPT codes 17106, 17107 and 17108, effective 1/1/11. Reviewed 12/2010 MPG Plastic Surgery and Dermatology, no coverage changes were made. Updated 3/1/2011, adding non-coverage of laser treatment of port wine stains when performed in combination with photodynamic therapy or with topical angiogenesis inhibitors, effective 3/1/2011. Updated 4/2011 to clarify continued coverage of tunable dye laser treatment of port wine stains of the face and neck without other medical necessity requirement. Updated 4/2011 to clarify documentation and authorization requirements and CPT code information for Laser treatment of hypertrophic scars. Reviewed 5/2011 MPG Pediatrics and Endocrinology, no changes in coverage were made. Reviewed 7/2011 MPG – Hematology and Oncology, no changes in coverage were made. Reviewed 9/2011 MPG – Urology, Obstetrics and Gynecology, no changes in coverage were made. Reviewed 11/2011 MPG – Plastic Surgery and Dermatology, no changes in coverage. Updated 1/18/2012 to add “port wine stains” to the second policy statement for clarity. Updated 1/1/2013 to include state mandated coverage of cleft lip, cleft palate or both. Updated 3/2013 to remove codes 67909 and 67911. Updated 8/2013 to exclude coverage for panniculectomy or abdominoplasty, with or without diastasis recti repair, for the treatment of back pain; and to exclude coverage

for abdominoplasty when done to remove excess skin or fat with or without tightening of the underlying muscles. Effective 8/1/2013. Updated 1/24/2014 to clarify coverage and noncoverage for labiaplasty. Updated 2/6/2014 - language on vitiligo was transferred to medical policy 911, Light Therapy for Vitiligo. Updated 6/2014 Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.

This document is designed for informational purposes only and is not an authorization, or an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

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