BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Corporate Medical Policy

Cosmetic and Reconstructive Procedures

File name: Cosmetic and Reconstructive Procedures
Origination: 11/1995
Last Review: 05/2009
Next Review: 05/2010
Effective Date: 05/19/2009

Description

The term, "plastic and reconstructive procedures" includes procedures ranging from purely cosmetic to purely reconstructive. Benefit application has the potential to be confusing to members because there is an area of overlap where cosmetic procedures may have a reconstructive component and reconstructive procedures may have a cosmetic component. These procedures are categorized and benefits are authorized based upon the fundamental purpose of the procedure. The American Medical Association and the American Society of Plastic Surgeons have agreed upon the following definitions:

- Cosmetic procedures are those that are performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.
- Reconstructive procedures are those procedures performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

In order to be considered medically necessary, the goal of reconstructive surgery must be to correct an abnormality in order to restore physiological function to the extent possible. As such, for reconstructive surgery to be considered medically necessary there must be a reasonable expectation that the procedure will improve the functional impairment.

Policy

Benefits are subject to all terms, limitations and conditions of the subscriber contract. For cosmetic and reconstructive services it is particularly important to consult the Member Certificate of Coverage and any "riders" prior to requesting services. Some certificates specifically exclude selected services through a "rider". (See "When Service or Procedure is not Covered" section of this policy.

Prior approval is required for all cosmetic and reconstructive surgery.

For New England Health Plan (NEHP) members an approved referral authorization is required.

Cosmetic surgery is considered not medically necessary and is a specific exclusion under the subscriber's contract.

Reconstructive surgery may be considered medically necessary if there is a reasonable expectation that the procedure will improve the functional impairment and therefore may be a covered benefit.

The muscles of facial expression have a communication function that may be considered in determining medical necessity as a reconstructive rather than cosmetic service.

Policy Guidelines

The prior approval of the procedure does not replace any contractual obligation the member or provider may have in regards to notification requirements regarding inpatient stays.

When service or procedure is covered

The following is not an all-inclusive list, but reflects some of the more frequently performed procedures requiring prior approval by the Plan(s):

Blepharoplasty (CPT codes 15820-15823) and Brow Ptosis Repair (67900 – 67908) - plastic surgery of the eyelid and/or eyebrow and forehead.

a. Documentation Required:
- Automated visual field study comparing taped to untaped visual fields, including interpretation and report
- Preoperative photographs -- one full-frontal view with patient looking directly at the camera and one view each of the eyes only looking upward and downward. If a combination of blepharoplasty and brow ptosis repair is requested, a photograph with forehead manually lifted to demonstrate that brow ptosis repair alone will not resolve the visual impairment.

b. Medical Necessity Criteria:
- 25 % documented reduction of untaped superior visual field in either eye compared to taped visual field, or
- frontal photograph noting 50% coverage of pupil by upper eyelid, and
- For brow ptosis repair, frontal photograph showing eyebrow below the orbital rim

c. Notes:
- Approval will be for a bilateral procedure

Breast surgery -- reduction mammaplasty (CPT code 19318) and augmentation mammaplasty (CPT code 19324-19325) for breast asymmetry - surgical reconstruction of the breasts by either reducing or enlarging.

a. Documentation Required:
- History and physical findings
- Height and weight
- Preoperative photograph
- Date of previous surgery, if applicable
- Pathologic diagnosis, if applicable
- Estimate of amount of tissue to be removed in a reduction or size of implant for augmentation.

b. Medical Necessity Criteria:
- Must be at least 15 years of age and have reached puberty, and
- Poland's syndrome (congenital absence of breast), or
- Breast asymmetry of at least "2 cup sizes" or estimated 300 grams differential

c. Notes:

- Allowance may be for either augmentation of the smaller breast or reduction of the larger breast, based upon member preference
- Following mastectomy and reconstruction for breast cancer, augmentation or reduction of the uninvolved breast is allowed for symmetry

Breast surgery -- reduction mammaplasty (CPT code 19318) – surgical reduction of breasts due to size and symptoms.

a. Documentation Required:
   - History and physical findings
   - Height and weight, utilizing the current Metropolitan Life Weight/Height table or calculated body surface area
   - Preoperative photograph
   - Estimate of amount of tissue to be removed

b. Medical Necessity Criteria:
   - Documentation of significant symptoms of greater than 6-week duration attributable to breast size, such as back, neck, or shoulder pain that is not responsive to conservative therapy, such as an appropriate support bra, exercises, hot/cold treatment, physical therapy, chiropractic care, and appropriate non-steroidal anti-inflammatory agents/muscle relaxants, or
   - Intertrigo (superficial dermatitis) between the breast and the pendulous chest wall that is refractory to conventional medical management, and
   - The average grams of tissue estimated to be removed per breast falls above the 22nd percentile on the Schnur Sliding Scale chart (Appendix), relative to the individual's body surface area (BSA);

Breast surgery – reconstruction following mastectomy (CPT codes 19340, 19342, 19350, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19380) – utilization of natural or artificial tissue to reconstruct breasts following mastectomy. When billed with a diagnosis of breast cancer prior approval is not required.

a. Documentation Required:
   - Diagnosis
   - Date and nature of proposed surgery

b. Medical Necessity Criteria:
   - Reconstruction is considered medically necessary following mastectomy

Breast surgery – prophylactic mastectomy (CPT codes 19180, 19182) – surgical removal of breasts due to cancer risk. When billed with a diagnosis of breast cancer prior approval is not required.

a. Documentation Required:
   - Clinical history outlining breast cancer risk factors including complete family history, and
   - BRCA1 or BRCA2 gene status if available, or
   - Pathologic report of lobular carcinoma in situ

b. Medical Necessity Criteria:
   - Personal history of breast cancer, or
   - Identical twin with breast cancer, or
   - One first-degree relative with bilateral breast cancer, or
   - Two or more first-degree relatives with breast cancer, or

- One first-degree relative and two or more second-degree or third-degree relatives with breast cancer, or
- One first-degree relative with breast cancer under age 45 and one other relative with breast cancer, or
- One first-degree relative with breast cancer and one or more relatives with ovarian cancer, or
- Two second-degree or third-degree relatives with breast cancer and one or more with ovarian cancer, or
- One second-degree or third-degree relative with breast cancer and two or more with ovarian cancer, or
- Three or more second-degree or third-degree relatives with breast cancer, or
- BRCA1 or BRCA2 positive women, or
- Lobular carcinoma in situ, or
- Members 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, or
- Members with such extensive mammographic abnormalities (i.e., calcifications) that adequate biopsy is impossible.

Breast surgery - removal of implant(s) (CPT codes 19328, 19330); insertion of implant(s) (CPT codes 19340, 19342); Periprosthetic capsulotomy or capsulectomy (CPT codes 19370, 19371)

a. Documentation Required:
   - History and physical findings
   - Date of implantation and type of implant
   - Objective evidence of leakage

b. Medical Necessity Criteria:
   - Explantation (removal of implant) of a silicone gel-filled implant is considered medically necessary for a documented implant rupture, extrusion, Baker class IV* Contracture, or surgical treatment of breast cancer, or
   - Explantation (removal of implant) of a saline-filled implant is considered medically necessary only in those members who had originally undergone breast implantation for reconstructive purposes (where implantation was or would have been considered medically necessary). Criteria are the same as above. And,
   - Explantation of a breast implant associated with a Baker Class III* contracture is considered medically necessary only in those patients who had originally undergone breast implantation for reconstructive purposes (where implantation was or would have been considered medically necessary). And,
   - Replacement implant or breast reconstruction is considered medically necessary only if the original implant was or would have been considered medically necessary (i.e. following mastectomy)

**Baker Classification of breast contractures:*

Grade I: Augmented breast feels as soft as a normal breast

Grade II: Breast is less soft and the implant can be palpated but is not visible

Grade III: Breast is firm, palpable, and the implant (or its distortion) is visible
Grade IV: Breast is hard, painful, cold, tender, and distorted

Breast surgery -Gynecomastia (CPT code 19300) - surgery due to development of abnormally large mammary gland in the male

a. Documentation Required:
- History of present illness and history and physical report
- Preoperative photograph

b. Medical Necessity Criteria:
- Over age 18; and
- Documented symptoms, including pain or tenderness directly related to the breast tissue, and which has a clinically significant impact upon normal activities of daily living despite non-narcotic analgesics and anti-inflammatory agents; and
- Appropriate diagnostic evaluation has been done for possible underlying etiology; and
- The tissue removed must be glandular breast tissue and not the result of obesity, adolescence, or reversible effects of drug treatment that can be discontinued. (This includes drug-induced Gynecomastia remaining unresolved six months after cessation of the causative drug therapy.) or
- There is a legitimate concern that the breast mass may be malignant.

Chemical Peels (CPT codes 15788 - 15793) including cryotherapy for acne (CPT codes 17340 & 17360 – procedures utilizing various chemicals or freezing agents (Carbon Dioxide Slush or liquid Nitrogen).

a. Documentation Required
- History of present illness and history and physical report
- Date of accident or injury, if applicable
- Photograph demonstrating affected area

b. Medical Necessity Criteria:
- Active acne when there is documented evidence of failure of a trial of topical retinoid treatment, topical antibiotic therapy, and oral antibiotic therapy, or
- Documented evidence of 10 or more actinic keratoses or other pre-malignant skin lesions that have failed topical retinoid treatment, topical chemotherapeutic agents, and cryotherapy.

Collagen Injections (CPT codes 11950 - 11954) – subcutaneous injection of filling material to restore physiologic function

c. Documentation Required
- History of present illness and history and physical report demonstrating physical impairment and presumptive cause (disease, trauma, congenital defect)

d. Medical Necessity Criteria:
- Documented evidence of significant functional impairment and the treatment can be reasonably expected to improve the functional impairment.

Dermabrasion (CPT codes 15780 - 15787) – surgical procedure for removal of scars on the skin by using sandpaper or mechanical methods on the frozen epidermis.

a Documentation Required
- History of present illness and history and physical report
- Date of accident or injury, if applicable
- Photograph demonstrating affected area

b. Medical Necessity Criteria:
- Restoration following previous injury or surgery with severe disfigurement or functional and physiological impairment. Or,
- Documented evidence of 10 or more superficial basal cell carcinomas, actinic keratoses, or other pre-malignant skin lesions that have failed topical retinoid treatment, topical chemotherapeutic agents, and cryotherapy.

Laser treatment of Port Wine Stains and Superficial Cavernous Hemangiomas (CPT codes 17106 – 17108)

a. Documentation Required
- History of present illness and physical examination report
- Photograph demonstrating affected area

b. Medical Necessity Criteria:
- Presence of lesions in an area in which the development of complications such as bleeding, thickening, and nodularity would be problematic and may require complex reconstruction (head, neck, hands, feet, and genitalia), or
- Development of complications listed above in other body areas, or
- Presence of functional impairment due to lesion

c. Notes:
- Extensive lesions may require more than one treatment and may require anesthesia.

Laser and Surgical Treatment of Rosacea (CPT codes 17106 – 17108, 30120, and 96920 – 96922)

a Documentation Required
- History of present illness including all previous attempts at treatment, current physical findings, and associated complications (bleeding, infection)
- Photograph demonstrating affected area

b. Medical Necessity Criteria:
- Severe and refractory rosacea, unresponsive to standard medical therapy including an adequate trial of topical agents and/or oral agents. And,
- Photo documentation demonstrates severity of disease with inflammatory papules and pustules. And,
- Planned therapy is directed toward current and potential complications rather than presence and appearance of telangiectasias

Lipectomy (including Panniculectomy, Abdominoplasty) (CPT code 15830 – 15839, 15847) - removal of fatty tissue

a. Documentation Required:
- History of present illness and physical examination
- Pre-operative photographs -- one full-body anterior photograph of the patient standing straight and one photograph of the abdominal fold,

raised to document any reported skin changes, e.g., dermatitis ulceration, and one lateral photograph

b. Medical Necessity Criteria:
   - Panniculus hangs below the level of pubis. And,
   - Documented weight loss is greater than 100 lbs or reduction in BMI of 16.2 (equivalent to 100 lbs in an individual of 5'6" height) or greater, or has reached a body mass index (BMI) of <30, and
   - Weight is stable for a period in excess of six months and, if weight loss is due to bariatric surgery, member is at least 18 months post-operative, and
   - Evidence of either a significant functional impairment such as difficulty with ambulation, activities of daily living, or initiation of a fitness program to sustain weight loss or of chronic skin rashes, local infection, cellulitis, or ulcers that does not respond to conventional treatment for a period of 3 months

c. Notes:
   - Suction assisted lipectomy (liposuction) (CPT codes 15876 – 15879) is considered to be cosmetic as a primary procedure and is not a covered benefit (see when services are not covered). Suction assisted lipectomy may be eligible for benefits under individual consideration as an adjunct to an authorized reconstructive procedure.

Otoplasty – Reconstruction of external auditory canal (69310, 69320) – for injury, infection, or congenital atresia

a. Documentation Required:
   - History and physical examination
   - Photographs

b. Medical Necessity Criteria:
   - Surgically correctable congenital malformation, trauma, surgery, infection, or other process that is causing hearing loss. [Audiogram must demonstrate a loss of at least 15 decibels in the affected ear(s).], or
   - to restore a significantly abnormal external ear or auditory canal related to trauma, tumor, surgery, infection, or congenital malformation, or
   - congenital absence of the external ear

Pectus excavatum or pectus carinatum repair (CPT Code 21740-21743) – reconstruction / repair of chest wall deformity

a. Documentation Required:
   - History and physical examination
   - Frontal and side photographs of chest
   - Statement from physician delineating cardiovascular and pulmonary risk

b. Medical Necessity Criteria:
   - Potential functional impairment of cardiovascular or pulmonary systems.

Psoralens with Ultraviolet A (CPT Code 96912) – Photochemotherapy; psoralens, and ultraviolet A (PUVA)

a. Documentation Required:
- History and physical examination
- Other forms of conservative therapy that have been attempted

b. Medical Necessity Criteria:
- Severe, disabling psoriasis, which is not responsive to other forms of conservative therapy (e.g., topical corticosteroids, coal/tar preparations, and ultraviolet light).

Rhinoplasty (CPT codes 30400 - 30462) - plastic surgery of the nose.

a. Documentation Required
- History of present illness and history and physical report
- Preoperative photographs -- one frontal view, one profile one view with head held back.
- Date of previous surgery, if applicable.
- Date of accident or injury, if applicable.
- Name & location of the treating physician at the time of accident.
- Emergency room or office records, including x-ray or x-ray reports, if available

b. Medical Necessity Criteria
- Airway obstruction from deformities due to disease, congenital abnormality or trauma that will not respond to septoplasty alone, or
- Immediate or planned-staged reconstruction following trauma.

Scar and Keloid Revision

a. Documentation Required
- History of present illness and history and physical report
- Preoperative photograph
- Date of accident or injury, if applicable
- Description of and CPT coding for planned staged procedure following acute repair, within two years of previous stage or initial primary repair

b. Medical Necessity Criteria
- Documentation of functional impairment or significant anatomic variance and the treatment can be reasonably expected to improve the impairment

Tattooing of the skin (CPT codes 11920 – 11922)

a. Documentation Required
- Clinical statement indicating tattooing is in conjunction with medically necessary procedure (i.e. nipple reconstruction post mastectomy)

b. Medical Necessity Criteria
- Approval of primary procedure

Testicular prosthesis Insertion (CPT 54660) – insertion of a prosthesis to replace a testicle due to congenital absence or surgical removal.

c. Documentation Required:
- Clinical statement by physician that testicle was either congenitally absent or was surgically removed (due to disease or trauma)
- Date and nature of proposed surgery

d. Medical Necessity Criteria:

- Insertion of a testicular prosthesis may be considered medically necessary due to congenital or acquired absence of a testicle.

When service or procedure is not covered

Services addressed under this policy which are subject to the Benefit Exclusion Rider if a member's certificate includes this exclusion.

Cosmetic procedures are considered not medically necessary and are a specific exclusion under the subscriber's contract. The following is a list that includes, but is not limited to, procedures that are considered cosmetic:

Breast surgery – Mastopexy (CPT code 19316) – surgical suspension of sagging breasts

Breast surgery – Nipple Correction (CPT code 19355) – surgical correction of inverted nipples.

Breast surgery - removal of implant(s) (CPT codes 19328, 19330); insertion of implant(s) (CPT codes 19340, 19342); Periprosthetic capsulotomy or capsulectomy (CPT codes 19370, 19371) for the following reasons:

- Systemic symptoms, attributed to connective tissue diseases, autoimmune diseases, etc., or
- Member anxiety, or
- Baker class III contractures in patients with implants for cosmetic purposes, or
- Rupture of a saline implant in patients with implants for cosmetic purposes, or
- Pain not related to contractures or rupture.

Chemical peels or dermabrasion for photo aged skin, wrinkles, acne scarring, or isolated (<10) actinic keratoses or other premalignant skin lesions, such that treatment of the individual lesions is practical.

Collagen injections or implants when performed in the absence of a significant functional impairment, are not reconstructive, and are intended to change physical appearance that would be considered within normal human anatomic variation (i.e., lip enhancement procedures).

Diastasis Recti correction – surgery to correct a separation of the lower abdominal muscles in the midline

Ear or Body Piercing – ear and body piercing are considered cosmetic and not medically necessary for all reasons

Hair Procedures – Hair transplant for alopecia (including male pattern alopecia) or hair removal (temporary or permanent) for all indications.

Laser treatment of telangiectasias

Otoplasty - (CPT code 69300) - plastic surgery of the ear to correct protruding ears. Correction of protruding ears, size or shape of ear lobes, or for clefts, tears, or other consequences of ear piercing is considered cosmetic and is not a covered benefit.

Removal of decorative tattoos

Suction assisted lipectomy (liposuction) (CPT codes 15876 – 15879) is considered to be cosmetic as a primary procedure and is not a covered benefit). However, suction assisted lipectomy may be eligible for benefits under individual consideration as an adjunct to an authorized reconstructive procedure.

Tattooing of the skin for color differentials or vitiligo. Psychological rationale for improving appearance does not constitute medical necessity;

Testicular prosthesis insertion as a component of intersex surgery (transsexual surgery)

When prior approval has not been obtained from the Plan

When all the above medical necessity criteria are not met.

Vermont Eligible Providers

Allopathic Physicians (M.D.)

Osteopathic Physicians (D.O.)

Information required

Requests for prior approval must be made to the Plan and should include the procedure requested, clinical information supporting need for procedure, other treatment information as appropriate. If photographs or slides are provided with the request and are originals they will be returned to the provider's office.

Policy Implementation/Update information

Supersedes all prior policies
02/2003 reformatted, 05/2002 updated medical necessity criteria, clarified TVHP requirements, and further defined reconstructive surgeries; 12/2001 added medical necessity criteria.
Updated 10/2005 clarification of clinical guidelines
Updated 11/2006 with addition of criteria for chemical peels, and laser treatment for rosacea, port wine stains, superficial hemangiomas, and tattooing.
Updated 11/2007 to incorporate criteria from BCBSA Medical Policies for Prophylactic Mastectomy, Reduction Mammaplasty, Reconstructive Breast Surgery/Management of Breast Implants, and Psoralens with Ultraviolet A (PUVA) and to add criteria for Otoplasty and testicular prosthesis. Reviewed by the CAC 01/2008
Updated 11/2008 to incorporate AMA and ASPS agreed upon definitions of cosmetic and reconstructive services, added criteria for collagen implantation, and modified criteria for reduction Mammaplasty and mastectomy for Gynecomastia,
Renewed without changes and approved by CAC 05/19/2009

Approved by BCBSVT Medical Policy Committee: Date Approved

Robert F. Griffin, M.D
Chairman, Medical Policy Committee

APPROVED FOR IMPLEMENTATION:

Allen J. Hinkle, M.D. Date Approved:_____
Chief Medical Director

APPENDIX

The Schnur Sliding Scale chart is an evaluation method for physicians to use on individuals considering breast reduction surgery. This method was developed by a plastic surgeon for use in a study that was done to determine the number of women who had breast reduction surgery for medical reasons only. Body surface area, along with average weight of breast tissue removed is incorporated into the chart to indicate the reason/motivation of the individual for breast reduction surgery. If the individual's body surface area and weight of breast tissue removed fall below the lower 22nd percentile, then the surgery is deemed not medically necessary. If the individual's body surface area and weight of breast tissue removed fall above the 22nd percentile, then the surgery is considered medically necessary with the appropriate criteria.

The original study did not address individuals with a body surface area greater than 2.55. BlueCross BlueShield of Tennessee utilized a mathematical equation in an attempt to address the greater body surface area (BSA) numbers. The data exhibited characteristics of an exponential trend. Using an exponential model (y=a^x), the grams of tissue removed for those with BSA > 2.55 were extrapolated.

Body surface area and cutoff weight of average breast tissue removed

Body Surface Area (m^2)	Average grams of tissue per breast to be removed
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978
2.30	1068
2.35	1167
2.40	1275
2.45	1393
2.50	1522
2.55	1662
2.60	1806
2.65	1972
2.70	2154
2.75	2352
2.80	2568
2.85	2804
2.90	3061
2.95	3343
3.00	3650
3.05	3985
3.10	4351
3.15	4750
3.20	5186

3.25	5663
3.30	6182
3.35	6750
3.40	7369
3.45	8045
3.50	8783
3.55	9589
3.60	10468
3.65	11428
3.70	12476
3.75	13619
3.80	14867
3.85	16230
3.90	17717
3.95	19340
4.00	21112
4.05	23045
4.10	25156
4.15	27459
4.20	29972
4.25	32716
4.30	35710
4.35	38977
4.40	42543
4.45	46435
4.50	50682
4.55	55316
4.60	60374
4.65	65893
4.70	71915
4.75	78487
4.80	85658

[1] Schnur, Paul L, et al., "Reduction Mammaplasty: Cosmetic or Reconstructive Procedure?" Annals of Plastic Surgery. Sept 1991; 27 (3): 232-7.

Simplified formula for calculation of body surface area:

(BSA (in m^2) = [height (cm)] $^{0.718}$ X [weight (kg)] $^{0.427}$ X .007449).

See website listed below for easy calculation:

http://www.bcbst.com/providers/calculator.asp

This document has been classified as public information.