APPENDIX to Reconstructive Services Policy

Prior Authorization Requirements

Clinical Evidence is required to determine **medical necessity**.

Within five days before the actual date of service, the Provider MUST confirm with Blue Shield of California / Blue Shield of California Life & Health Insurance Company (Blue Shield) that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should also be directed to the Prior Authorization Department. Please call 1-800-541-6652 or visit the Provider Portal www.blueshieldca.com/provider.

Evidence Basis for the Policy

Rationale

Blue Shield of California's intent is to use definitions and make determinations consistent with the Reconstructive Surgery Act (AB 1621) which was added to the California Health and Safety Code (Section 1367.63), Insurance Code (Section 10123.88) and Welfare and Institutions Code (Section 14132.62). AB 1621 (Figueroa and Leach) - As Amended: February 19, 1998. Summary: Requires health insurance and health maintenance organization (HMO) contracts to cover reconstructive surgeries. Specifically, this bill:

- Provides that health care service plans and disability insurers that cover hospital, medical or surgical benefits, including entities that provide Medi-Cal coverage, shall cover reconstructive surgeries
- Defines reconstructive surgery as surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease if the surgery will either improve function or give a patient a normal appearance

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program (FEP)) prohibit Plans from denying Food and Drug Administration (FDA) - approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement.

Type	Number	Description
CPT	11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
	11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
	11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
	15775	Punch graft for hair transplant; 1 to 15 punch grafts
	15776	Punch graft for hair transplant; more than 15 punch grafts
	15786	Abrasion; single lesion (eg, keratosis, scar)
	15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
	15819	Cervicoplasty
	15824	Rhytidectomy; forehead
	15826	Rhytidectomy; glabellar frown lines
	15828	Rhytidectomy; cheek, chin, and neck
	15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
	15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
	15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg

Type	Number	Description
	15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
	15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
	15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
	15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
	15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
	15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
	15876	Suction assisted lipectomy; head and neck
	15877	Suction assisted lipectomy; trunk
	15878	Suction assisted lipectomy; upper extremity
	15879	Suction assisted lipectomy; lower extremity
	19316	Mastopexy
	19324	Mammaplasty, augmentation; without prosthetic implant
	19325	Mammaplasty, augmentation; with prosthetic implant
	19350	Nipple/areola reconstruction
	19355	Correction of inverted nipples
	19370	Open periprosthetic capsulotomy, breast
	21086	Impression and custom preparation; auricular prosthesis
	21137	Reduction forehead; contouring only
	21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
	21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
	21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
	21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial

Type	Number	Description
	21270	Malar augmentation, prosthetic material
	21280	Medial canthopexy (separate procedure)
	21282	Lateral canthopexy
	21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
	21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy
	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
	30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
	30420	Rhinoplasty, primary; including major septal repair
	30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
	30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
	30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
	55970	Intersex surgery; male to female
	55980	Intersex surgery; female to male
	56805	Clitoroplasty for intersex state
	57291	Construction of artificial vagina; without graft
	57292	Construction of artificial vagina; with graft
	57335	Vaginoplasty for intersex state
HCPC	C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (lds) and provision of radiesse or sculptra dermal filler, including all items and supplies
	G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (lds) (e.g., as a result of highly active antiretroviral therapy)

Type	Number	Description
	Q2026	Injection, radiesse, 0. 1 ml
	Q2028	Injection, sculptra, 0. 1 ml
	S0196	Injectable poly-l-lactic acid, restorative implant, 1 ml, face (deep dermis, subcutaneous layers)
ICD9 Procedure	None	
ICD9 Diagnosis	All Diagnoses	
Place of Service	All Places of Service	

Tables

N/A

Definitions

N/A

Index / Cross Reference of Related BSC Medical Policies

The following Medical Policies share diagnoses and/or are equivalent BSC Medical Policies:

- Blepharoplasty, Blepharoptosis Repair, and Brow Lift
- Breast Implant Management
- Gynecomastia Surgery
- Laser and Light Therapy for Acne Vulgaris
- Laser and Targeted Phototherapy for Psoriasis
- Non-Pharmacologic Treatment of Rosacea
- Panniculectomy, Abdominoplasty and Surgical Management of Diastasis Recti
- Orthognathic Surgery
- Photodynamic Therapy for the Treatment of Actinic Keratoses and Other Skin Lesions
- Reduction Mammaplasty
- Varicose Vein Treatments

Key / Related Searchable Words

N/A

References

- Reconstructive Surgery Act (AB 1621). 1998. Retrieved October 23, 2009 from http://info.sen.ca.gov/pub/97-98/statute/ch_0751-0800/ch_788_st_1998_ab_1621.

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action	Reason
1/11/2008	New Policy Adoption New Medical policy Adoption	Medical Policy Committee
4/25/2008	Policy Revision Revised Medical Policy. Policy title change from Cosmetic and Reconstructive Services	Medical Policy Committee
12/18/2009	Policy revision without position change Coding update	Medical Policy Committee
7/2/2010	Coding Update	Administrative Review
9/13/2010	Coding Update	Administrative Review
10/6/2010	Coding Update	Administrative Review
1/4/2011	Coding Update	Administrative Review
1/21/2011	Coding Update	Administrative Review
9/1/2011	Policy statement reformatted and coding update	Administrative Review

Effective Date	Action	Reason
3/29/2013	Coding Update	Administrative Review
5/2/2014	Coding Update	Administrative Review

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.

Click here to view the policy statement for this policy

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