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Medical Policy Manual

Topic: Cosmetic and Reconstructive Surgery

Date of Origin: January 1996

Section: Surgery

Last Reviewed Date: July 2014

Policy No: 12

Effective Date: October 1, 2014

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Cosmetic surgery is performed to reshape normal body structures in order to improve appearance.

Reconstructive surgery is primarily performed to improve or correct a functional impairment.

MEDICAL POLICY CRITERIA

Many member contracts have very specific language regarding covered reconstructive services and excluded cosmetic procedures. Specific member contract language has precedence over medical policy, and requests for coverage of potentially cosmetic services should be reviewed by applicable member contract language.

I. Medical necessity criteria for specific procedures:

Blepharoplasty and Brow Ptosis Repair

Chemical Peels

Dermabrasion and Microdermabrasion

Laser Treatment for Port Wine Stain

Mastectomy for Gynecomastia

Orthognathic Surgery

Pectus Excavatum

Reconstructive Breast Surgery/Mastopexy, and Management of Breast Implants

Reduction Mammaplasty

Varicose Vein Treatment

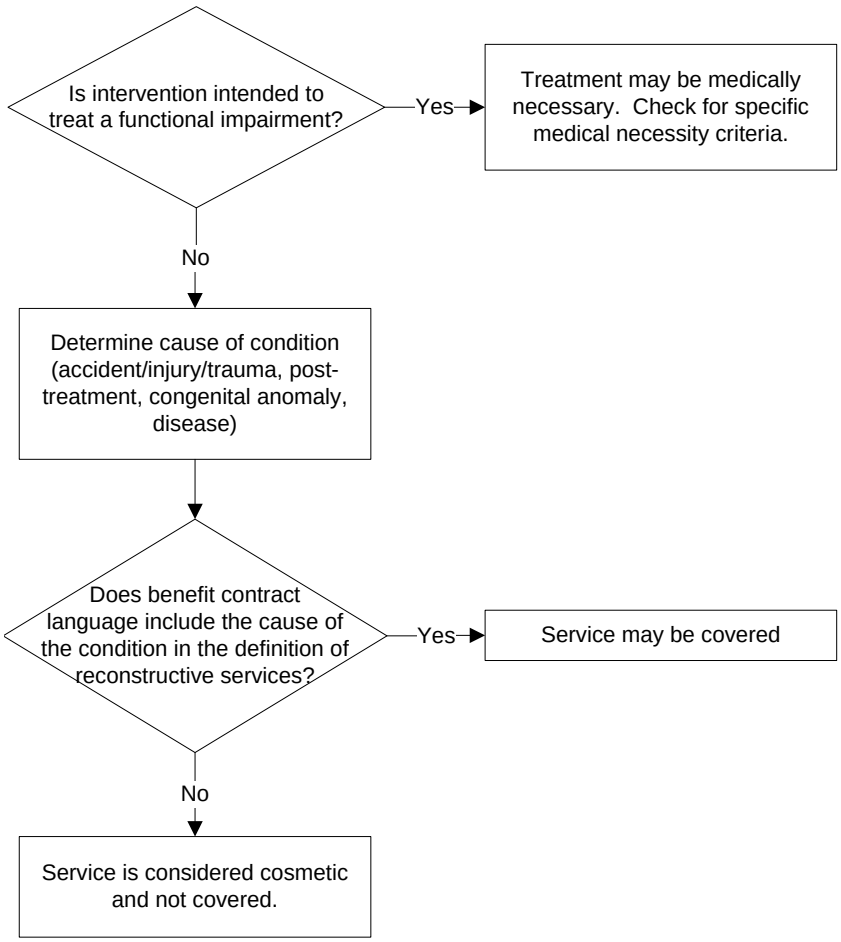
Ventral Hernia Repair

II. The following criteria may be applied when member contract language is not specific:

A. If the intervention is intended to treat a functional impairment and if no other contract exclusions apply, it may be considered **medically necessary**.

B. If the intervention is not intended to treat a functional impairment, the cause of the condition must be determined, for example, accident/injury/trauma, post-treatment, congenital anomaly, disease. If the cause is included in the definition of reconstructive services in the benefits contract language, then the treatment may be covered.

The following flow chart may be used as a guide to interpreting benefits language.



Blepharoplasty and Brow Ptosis Repair Return to Flow Chart

Description

Blepharoplasty is a surgical procedure performed on the upper and/or lower eyelids to remove or repair excess tissue that obstructs the field of vision. These procedures may also be performed for cosmetic purposes in the absence of visual field obstruction.

Functional visual impairment occurs when excess upper eyelid tissue overhangs the upper eyelid margin and results in significant superior visual field obstruction. Visual field studies are used to determine the degree of obstruction. Visual field studies should be measured both with and without elevation of the excess tissue to determine the extent of visual field defect at rest and the amount of improvement that may be obtained from blepharoplasty.

Medical Policy Criteria

I. In order to determine medical necessity the following information will be requested:

   A. Visual fields, including physician interpretation

   B. Documentation of clinically decreased vision

   C. Lateral and full face photographs

II. Blepharoplasty for the following diagnoses may be considered **medically necessary** for an affected upper or lower lid without meeting visual loss criteria:

   A. Trichiasis

   B. Ectropion

   C. Entropion

III. In the absence of one of the conditions listed above, unilateral or bilateral upper lid blepharoplasty or levator resection may be considered **medically necessary** for reconstructive purposes when at least one eye meets all of the following criteria:

   A. Visual field is limited to 20 degrees or less superiorly, or limited to 10 to 15 degrees or less laterally, AND

   B. Frontal or lateral photographs demonstrate visual field limitation consistent with the visual field examination, AND

   C. Any related disease process, such as myasthenia gravis or a thyroid condition is documented as stable.

IV. Brow ptosis repair may be considered **medically necessary** for reconstructive purposes when at least one eye meets all of the criteria for blepharoplasty above, and photographs demonstrate the eyebrow is below the supraorbital rim.

V. Blepharoplasty in anophthalmia may be considered **medically necessary** when the upper eyelid position interferes with the fit of a prosthesis in the socket.

VI. Unilateral or bilateral upper lid blepharoplasty, levator resection and brow ptosis repair is considered **cosmetic** when the criteria in II, III, IV and V above are not met.

VII. Blepharoplasty of the lower lids for excessive skin is considered **cosmetic**.

Chemical Peels[1] **Return to Flow Chart**

Description

A chemical peel refers to a controlled removal of varying layers of the epidermis and superficial dermis with the use of a 'wounding' agent, such as phenol or trichloroacetic acid (TCA). The most common indication for chemical peeling is as a treatment of photoaged skin, correcting pigmentation abnormalities, solar elastosis, and wrinkles. However, chemical peeling has also been used as a treatment for various stages of acne and multiple actinic keratoses when treatment of individual lesions is not feasible.

An epidermal peel may be used to remove fine, subtle lines, soften the appearance of enlarged pores, improve the skin texture and lighten hyper-pigmentary disorders. Multiple epidermal peels (also referred to as chemical exfoliation) may also be used in patients with active acne.

Dermal peels may be used to treat deep wrinkling, actinic damage, or actinic keratoses. Acne scarring has also been treated with dermal peels.

Medical Policy Criteria

Epidermal Chemical Peels

I. Epidermal chemical peels with 50 - 70% alpha hydroxy acids may be considered **medically necessary** as a treatment of active acne that has failed to respond to a trial of topical and/or oral antibiotic acne therapy.

II. Epidermal chemical peels with 50 - 70% alpha hydroxy acids is considered **not medically necessary** as a first-line treatment of active acne.

III. Epidermal chemical peels for the treatment of photoaged skin, wrinkles, or acne scarring are considered **cosmetic**.

Dermal Chemical Peels

I. Dermal chemical peels may be considered **medically necessary** to treat numerous (>10) actinic keratoses or other premalignant skin lesions, when treatment of the individual lesions becomes impractical.

II. Dermal chemical peels are considered **not medically necessary** to treat less than 10 actinic keratoses or other premalignant skin lesions.

II. Dermal chemical peels as treatments of end-stage acne scarring are considered **cosmetic**.

Dermabrasion and Microdermabrasion Return to Flow Chart

Description

Dermabrasion uses a rapidly moving brush to remove skin and activate new skin growth. It is commonly used for the treatment of facial scars and wrinkles.

Microdermabrasion uses small microcrystals to abrade the superficial epidermal layer of the skin; suction is then used to remove any skin debris. Microdermabrasion is often performed by estheticians for facial rejuvenation.

Medical Policy Criteria

I. Dermabrasion to treat photoaged skin, wrinkles, or acne scarring is considered **cosmetic**.

II. Microdermabrasion for the treatment of any indication is considered **cosmetic**.

Laser Treatment of Port Wine Stains[2] Return to Flow Chart

Description

Port wine stain (PWS) is a capillary malformation that begins as a pale pink flat area (macular lesion) in childhood and grows as the patient ages. Common areas for PWS to appear are on the face over the areas of the first and second trigeminal nerves and the eyes or mouth. It is common to see a PWS overlying an arteriovenous, arterial or venous malformation. The abnormal blood vessels within the PWS become progressively more dilated in size, which results in the lesion becoming dark purple and elevated in some instances. Nodules and hypertrophy may develop in the soft tissue underlying the PWS. Nodules may continue to grow and can bleed easily if traumatized. PWS persists into adult life and is associated with systemic abnormalities such as glaucoma.

Treatment of a PWS in its macular stage will prevent the development of the hypertrophic component of the lesion. Laser treatment of a PWS diminishes the existing blood vessels making them smaller, fewer in number, and less likely to progress in size.

Medical Policy Criteria

I. Laser treatment may be considered **medically necessary** for port wine stains.

II. Destruction of cutaneous vascular lesions for removal of telangiectasias (spider veins) is considered **cosmetic**.

Mastectomy for Gynecomastia[3] Return to Flow Chart

Description

Gynecomastia refers to the benign enlargement of the male breast, either due to increased adipose tissue, fibrous tissue, glandular tissue, or a combination of all three. In some instances, adolescent gynecomastia may be reported as tender or painful; however, this pain is normally self-limiting or responds to analgesic therapy. Typically no functional impairment is associated with gynecomastia.

Medical Policy Criteria

Mastectomy as a treatment of gynecomastia is considered **cosmetic**.

Pectus Excavatum Repair Return to Flow Chart

Description

Pectus excavatum, commonly referred to as "funnel chest," is a chest wall malformation in which the sternum is depressed inward, causing midline narrowing of the thoracic cavity. Although pectus excavatum may be visually prominent, in most cases the loss of volume is not significant and does not interfere with ventilation. Pectus excavatum is occasionally associated with upper or lower airway obstruction; however, when this condition is successfully treated or resolves spontaneously, the pectus deformity may lessen or disappear. Pectus excavatum may also be associated with segmental bronchomalacia, and in some patients, cardiac function may be adversely affected. In many children, the heart is shifted leftward, and in the rare patient, cardiac function may be adversely affected.

Surgical correction of pectus excavatum is not physiologically beneficial for the vast majority of patients; surgery is most often sought due to psychological and cosmetic concerns. However, for some patients with extreme deformity, operative interventions may be indicated for functional reasons.

Medical Policy Criteria

I. Surgical repair of pectus excavatum may be considered **medically necessary** in children or adults when at least two of the following medical necessity criteria are met:

   A. Documented progression of the deformity with associated symptoms.

   B. Pulmonary function studies indicate components of restrictive airway disease.

   C. Haller Computerized Tomography (CT) scan index greater than 3.25. This Haller CT index is the ratio derived from a chest CT scan by dividing the transverse diameter by the anterior-posterior diameter.

   D. Cardiac evaluation (electrocardiogram [EKG], chest CT, and/or echocardiogram) demonstrates compression-caused mitral valve prolapse, abnormal rhythm, conduction abnormalities, or significant cardiac deformity.

II. Surgical repair of pectus excavatum that does not meet at least two of the criteria in I.A. – I. D. above is considered **not medically necessary**.

Ventral Hernia Repair

Return to Flow Chart

Description

Ventral hernias occur in the abdomen and develop when a portion of the lining of the peritoneum pushes through a weak area of the abdominal wall fascia. This results in a protrusion which can be filled with intra-abdominal fat or intestine. Ventral hernias are usually acquired when pressure is applied to an area of the abdomen which is weakened. Abdominal wall hernias: Epigastric, Umbilical, Lumbar and Spigelian which are defined by their anatomical location. Patients who are obese, older, under-weight, pregnant, have ascites or other factors which increase intra-abdominal pressure may be predisposed to developing abdominal hernias. They can occur spontaneously, known as a primary hernia, or at the site of a previous surgical incision, known as an incisional hernia. Most hernias are acquired; however, the occurrence of umbilical hernias in infants is considered a congenital defect which usually resolves before the age of 2. Children with persistent symptoms may require surgical repair.
In general small, asymptomatic hernias do not require surgical repair. Adults with larger, symptomatic hernias should be considered for ventral hernia repair. Hernia symptoms may include pain, bowel obstruction, incarceration, thinning of the overlying skin, strangulation and displacement of abdominal contents into the hernia itself, known as loss of abdominal domain.

Medical Policy Criteria

I. Surgical repair of a ventral hernia may be considered **medically necessary** in symptomatic patients when there is documentation of any one of the following criteria:

   A. Hernia associated pain
   B. Bowel obstruction
   C. Incarceration
   D. Strangulation
   E. Thinning of the overlying skin
   F. Loss of abdominal domain

II. Surgical repair of asymptomatic ventral hernias, or ventral hernias found incidentally during surgery, is considered **not medically necessary.**

REFERENCES

1. BlueCross BlueShield Association Medical Policy Reference Manual "Chemical Peels." Policy No. 8.01.16
2. BlueCross BlueShield Association Medical Policy Reference Manual "Laser Treatment of Port Wine Stains." Policy No. 7.01.40
3. BlueCross BlueShield Association Medical Policy Reference Manual "Surgical Treatment of Bilateral Gynecomastia." Policy No. 7.01.13

CROSS REFERENCES

Reconstructive Breast Surgery/Management of Breast Implants, Surgery, Policy No. 40

Reduction Mammaplasty, Surgery, Policy No. 60

Varicose Vein Treatment, Surgery, Policy No. 104

Orthognathic Surgery, Surgery, Policy No. 137

Autologous Fat Grafting to the Breast and Adipose-derived Stem Cells, Surgery, Policy No. 182

CODES	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
	15775	Punch graft for hair transplant; 1 to 15 punch grafts
	15776	Punch graft for hair transplant; more than 15 punch grafts
	15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
	15781	Dermabrasion; segmental, face
	15782	Dermabrasion; regional, other than face
	15783	Dermabrasion; superficial, any site (eg, tattoo removal)
	15786	Abrasion; single lesion (eg, keratosis, scar)
	15787	Abrasion; each additional four lesions or less
	15788	Chemical peel, facial; epidermal
	15789	Chemical peel; facial; dermal
	15792	Chemical peel; nonfacial; epidermal
	15793	Chemical peel; nonfacial; dermal

CODES	NUMBER	DESCRIPTION
	15819	Cervicoplasty
	15820	Blepharoplasty, lower eyelid
	15821	Blepharoplasty with extensive herniated fat pad
	15822	Blepharoplasty, upper eyelid
	15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
	15824	Rhytidectomy; forehead
	15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
	15826	Rhytidectomy; glabellar frown lines
	15828	Rhytidectomy; cheek, chin and neck
	15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
	15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
	15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
	15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
	15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
	15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
	15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
	15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
	15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
	15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area

CODES	NUMBER	DESCRIPTION
	15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication)
	15876	Suction assisted lipectomy; head and neck
	15877	Suction assisted lipectomy; trunk
	15878	Suction assisted lipectomy; upper extremity
	15879	Suction assisted lipectomy; lower extremity
	17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm
	17107	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq cm
	17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50 sq cm
	17360	Chemical exfoliation for acne (eg, acne paste, acid)
	17380	Electrolysis epilation, each 30 minutes
	17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
	19300	Mastectomy for gynecomastia
	19355	Correction of inverted nipples
	21137	Reduction forehead; contouring only
	21138	Reduction forehead; contouring and application of contouring material or bone graft (includes obtaining autograft)
	21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
	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

CODES	NUMBER	DESCRIPTION
	21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
	21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete
	21270	Malar augmentation, prosthetic material
	21280	Medial canthopexy
	21282	Lateral canthopexy
	21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach
	21296	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach
	21740	Reconstructive repair of pectus excavatum or carinatum; open
	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
	26590	Repair macrodactylia, each digit
	30120	Excision or surgical planing of skin of nose for rhinophyma
	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)

CODES	NUMBER	DESCRIPTION
	31830	Revision of tracheostomy scar
	41510	Suture of tongue to lip for micrognathia (Douglas type procedure)
	49250	Umbilectomy, omphalectomy, excision of umbilicus
	49560	Repair initial incisional or ventral hernia, reducible
	49565	Repair recurrent incisional or ventral hernia, reducible
	54360	Plastic operation on penis to correct angulation
	57291	Construction of artificial vagina; without graft
	57292	Construction of artificial vagina; with graft
	57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
	57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
	57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
	67900	Repair or brow ptosis (supraciliary, mid-forehead or coronal approach)
	67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
	67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
	67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
	67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
	67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
	67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)
	67909	Reconstruction of overcorrection of ptosis

CODES	NUMBER	DESCRIPTION
	67911	Correction of lid retraction
	67916	Repair of ectropion; excision tarsal wedge
	67917	Repair of ectropion; extensive (eg, tarsal strip operations)
	67923	Repair of entropion; excision tarsal wedge
	67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operations)
	67950	Canthoplasty (reconstruction of canthus)
	69090	Ear piercing
	69300	Otoplasty, protruding ear, with or without size reduction
HCPCS	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)
	Q2026	Injection, Radiesse, 0.1 ML
	~~Q2027~~	~~Injection, Sculptra, 0.1 ML~~ (Deleted 1/1/14)
	Q2028	Injection, Sculptra, 0.5 mg