

## Cosmetic and Reconstructive Surgery

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**All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.\*.**

### Purpose:

This policy addresses Cosmetic and Reconstructive Surgery.

### Description & Definitions:

**Congenital anomalies** are birth defects, congenital disorders or congenital malformations.

**Cosmetic surgery** improvement or enhance appearance or self-esteem that does not improve function.

- Defined as any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper functioning of the body or prevent or treat illness or disease

**Reconstructive surgery** is the use of surgery to repair or restore form of the body when congenital defects, developmental abnormalities, trauma, surgery, accidental injury, infection, tumors or disease cause loss of function or approximate normal appearance.

### Criteria:

**Reconstructive surgery** is considered medically necessary for **1 or more of the following**:

- Acute injury to the ear lobe(s) which require suturing, as a result of ear adornments being accidentally pulled out with **1 or more of the following**:
  - The individual seeks prompt or immediate care within 72 hours of the tear/injury
  - There is a delay in access to care due to understandable reason (e.g. injury occurs on a weekend or holiday etc.)
- Medium and deep chemical peels with **ALL of the following**:
  - Actinic keratoses and other pre-malignant skin lesions
  - Individual has 15 or more lesions, such that it becomes impractical to treat each lesion individually using conventional methods, cryotherapy, curettage, and excision

- Individual has failed to adequately respond to treatment with topical 5-FU or imiquimod, or these are contraindicated.
  - Congenital defects for 1 or more **of the following**:
    - Plastic repair to correct a congenital defect or lesion which causes anatomical functional impairment (Facial deformities (ie. Lymphangiomas, Hemangiomas) that may cause impairment from ongoing growth may be considered on an individual basis by the Medical Director)
    - Reconstructive surgery to correct congenital problems resulting in functional impairment regardless of how long the member has been enrolled
  - Dermabrasion and surgery planned to correct defects resulting from traumatic injury, surgery, or removal of superficial basal cell carcinomas and pre-cancerous actinic keratoses disease when ALL of the following criteria are met:
    - When conventional methods of removal are impractical due to pattern or number of lesions.
    - Unless contraindicated, member has failed a trial of 5-fluorouracil (5-FU) (Efudex) or imiquimod (Aldara).
  - Disease which causes an anatomical/functional impairment, if the disease occurred on or after the effective date of the members coverage
  - Excessive skin/redundant tissue removal with **ALL of the following**:
    - Documentation to include **1 or more of the following**:
      - Photographic evidence (with the excess or redundant skin lifted) of conditions refractory to medical therapy (e.g. analgesics, antibiotics, antifungals) for at least 6 months
      - Functional impairment
    - Individual must meet criteria for **1 or more of the following**:
      - Post bariatric surgery with **all of the following**
        - At least 18 months post-operative
        - Documented stable weight for at least 3 months with **1 or more of the following**:
          - Reached a body mass index (BMI) less than or equal to 30 kg/m<sup>2</sup>
          - Has documented at least a 100 pound weight loss
          - Has achieved a weight loss which is 40% or greater of the excess body weight that was present prior to the bariatric surgery
      - Individuals with a body mass index (BMI) greater than 30 and has not had bariatric surgery with **ALL of the following**:
        - Compliance with a 6 month program of medically supervised weight loss within 24 months of the request with **ALL of the following**:
          - Frequency of program visits is at least monthly
          - Evidence of programmatic support of diet and activities associated with normalization
        - Individual meets **1 or more of the following**:
          - Has documented at least a 100 pound weight loss
          - Has achieved a weight loss which is 40% or greater of the excess body weight that was present prior to the non-surgical intervention
- Plastic repair of non-healing pilonidal cyst(s)
- Traumatic injury which causes an anatomical/functional impairment, if the injury occurred on or after the effective date of the members coverage

**Cosmetic or reconstructive surgeries** are considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Aesthetic operations on umbilicus
- Any procedure for photo-aged skin, wrinkles
- Buttock lift or augmentation
- Cervicoplasty
- Chemical exfoliation for acne and all other indications (17360)
- Chemical Peels for the following indications:
  - Acne scarring
  - Active Acne Vulgaris
  - Photoaged skin
  - Uneven epidermal pigmentation
  - Wrinkles
- Correction of diastasis recti abdominis

- Cosmetic/plastic surgery for the improvement of a member's appearance or self-esteem whether or not for psychological or emotional reasons
- Dermabrasion for post-acne scarring
- Dermabrasion for tattoos applied by medical professional in the course of therapeutic intervention
- Ear Lobe Repair: Non-acute or delayed suture or revision of healed wounds (more than 72 hours post tear/injury)
- Electrolysis or laser hair removal
- Fat, or tissue grafting except for Breast Reconstruction, See Policy Surgical 10
- Female Circumcision regardless of the documentation of symptoms
- Implants including malar and chin
- In the event of a request for repeat surgical intervention when the initial surgery was deemed unsuccessful and additional surgery is not likely to correct the functional defect, but simply to restore the anatomy close to its previous form, the procedure is not a covered benefit
- Inverted nipple or correction of inverted nipple
- Lymphangiomas, Hemangiomas, Port Wine stains, Spider Angiomata as well as other lesions that have no evidence of rapid growth, functional impairment or likelihood of future threats to organ function
- Mesotherapy (injection of various substances into the tissue beneath the skin to sculpt body contours by lysing subcutaneous fat)
- Neck tucks
- Removal of frown lines
- Removal of supernumerary nipples (polymastia)
- Restoration of an anatomical defect that does not significantly affect functioning
- Salabrasion-for tattoo removal-cosmetic
- Suction assisted lipectomy
- Surgical corrections to the ear are considered cosmetic and not medically necessary when intended to change a physical appearance that would be considered within normal human anatomic variation. (Examples include, but are not limited to, repair of an ear lobe with cleft, accessory tragus, otoplasty, or protruding ears)
- Surgical depigmentation of nevus of Ito or Ota whether by laser treatment or other means
- The excision of suprapubic fat pad and use for tissue grafting for a procedure directed at improving the member's appearance and not restoring proper function of the body
- Umbilicus repair
- Vaginal rejuvenation procedures (designer vaginoplasty, revirgination, G-spot amplification, reduction of labia minora)

## Coding:

### Medically necessary with criteria:

Coding	Description
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
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)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal

15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
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

**Considered Not Medically Necessary:**

Coding	Description
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucousmembranes; 2.5 cm or less
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15819	Cervicoplasty

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
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17340	Cryotherapy (CO2 slush, liquid N2) for acne
17360	Chemical exfoliation for acne (eg, acne paste, acid)
17380	Electrolysis epilation, each 30 minutes
69300	Otoplasty, protruding ear, with or without size reduction

U.S. Food and Drug Administration (FDA) - approved only products only.

## Document History:

### Revised Dates:

- 2024: January
- 2022: February
- 2021: January, November
- 2016: March
- 2015: February
- 2014: January, March
- 2013: February, March, June
- 2012: February, June
- 2011: November
- 2009: February
- 2008: February, September
- 2005: December
- 2003: October
- 2001: June
- 2000: December
- 1998: December
- 1994: February

### Reviewed Dates:

- 2023: January
- 2020: January

- 2018: April
- 2011: February
- 2010: February
- 2009: September
- 2007: December
- 2006: October
- 2004: October, December
- 2003: September
- 2002: May, September
- 1999: November
- 1996: June

Effective Date:

- May 1991

## References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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### Special Notes: \*

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

### Keywords:

Reconstruction, congenital defects, pilonidal cyst, torn ear lobe, reconstructive surgery, excess skin removal, redundant skin removal, SHP Reconstructive Surgery, SHP Surgical 03, cosmetic surgery, bariatric surgery, labiaplasty, vulvectomy, acute injury, traumatic injury, congenital anomalies