Sentara Health Plans

Medicaid

Cosmetic and Reconstructive Surgery, Surgical 03

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Coverage Policy	Surgical 03
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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 by 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.*.

Description & Definitions:

Cosmetic/plastic surgery is performed for the improvement (shape, size and symmetry) of an individuals' appearance or self-esteem for psychological or emotional reasons.

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

Reconstructive and Restorative surgery is performed to alleviate physical functional impairment, persistent skin conditions and interference with an individuals' everyday living.

Restoration is a surgical type of procedure of a physical and/or functional condition following an injury or illness to a natural-looking appearance.

Examples include Non-healing pilonidal cyst(s), pre/post cancer treatment correction, acute injury of earlobe, scars that restrict movement. Excludes Gender affirming surgery and Gender dysphoria, refer to Surgical 108.

Criteria:

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

- Acute injury to the ear lobe(s) which require suturing within 72 hours of injury
- Congenital defects or lesions
- Correction of injury or illness which are causing an anatomical/functional impairment
- Dermabrasion and surgery planned to correct defects resulting removal of superficial basal cell carcinomas and pre-cancerous actinic keratoses disease
- **Excessive skin/redundant tissue removal** with **ALL** of the following:
    - Functional impairment with **ALL** of the following
        - Recurrent ulceration, and/or intertrigo dermatitis
        - 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
        - Impairment causing restrictions and limitations such as difficulty with walking and Activities of Daily Living (ADLs)

    - Weight Loss with **1 or more** of the following:
        - Documentation of at least a 100 pound weight loss and stable for at least 3 months
        - Post Bariatric surgery with **ALL** of the following:
            - Documentation of weight loss which is 40% or greater of the excess body weight that was present prior to the bariatric surgery and stable for at least 3 months
            - At least 18 months post-operative, documented stable weight for at least 3 months
- Facial deformities (ie. Lymphangiomas, Hemangiomas) from ongoing growth may be considered by the Medical director on a case-by-case basis.
- Medium and deep chemical peels for Actinic keratoses and other pre-malignant skin lesions
- **Initial Pulse-dye Laser Therapy/ YAG laser** is considered medically necessary for **1 or more** of the following:
    - Acne keloidalis nuchae (AKN) with extensive scarring observed in plaque or tumor stage
    - Genital warts when home therapy with **1 or more** of the following has been unsuccessful:
        - Podophyllotoxin
        - Imiquimod
    - Granuloma faciale
    - Hidradenitis Suppurativa
    - Keloid or other hypertrophic scars resulting in substantial loss of function
    - Keloids/Hypertrophic scars cause substantial pain necessitating constant pain relief medication
    - Hair removal for recurrent pilonidal cyst
    - Mild-to-moderate localized plaque psoriasis
    - Multiple cutaneous and/or deep tissue hemangiomas, port wine stains and other vascular malformation (e.g., venous, arteriovenous, lymphatic) on the face and neck where surgical removal is not feasible
    - Numerous glomangiomas superficially located in the face and neck where surgical removal is not feasible
    - Penile intraepithelial neoplasia
    - Pyogenic granuloma in the face and neck
    - Refractory Actinic keratoses
    - Verrucae (warts) when standard treatments have failed
- **Repeat or continued Pulse-dye Laser Therapy/ YAG laser** for **1 or more** of the following:
    - **Treatment of mild to moderate localized plaque psoriasis** is considered medically necessary with **ALL** of the following:
        - No more than 13 laser treatments per course or three courses per year
        - Individual has documentation showing favorable clinical response to initial course of laser therapy
    - **Treatment of vitiligo** is considered medically necessary with **ALL** of the following:
        - No more than 200 total treatments
        - Individual has documentation showing favorable clinical response to initial course of laser therapy
- **Nasal Repair** are considered medically necessary for **1 or more** of the following:
    - Nasal obstruction/nasal valve collapse with **1 or more** of the following:
        - Clinical findings of collapsed internal nasal valve at rest or collapsed external nasal valve (lateral walls) with inspiration.
        - Nasal reconstruction to prevent development of nasal valve narrowing after removal of large cutaneous defect (eg, cutaneous malignancy)
    - Nasal perforation repair with or without implant for **1 or more** of the following
        - Failed all other treatment options
- **Panniculectomy** is considered medically necessary for **ALL** of the following:
    - Documentation of Panniculus with **ALL of** the following:
        - Pannuiculus hangs below the level of the pubis (Photographs included)
        - Panniculus causes **1 or more** of the following:
            - Skin impairment (Chronic intertrigo, rashes, cellulitis, infections, or non-healing ulcers)
            - Impairment causing restrictions and limitations such as difficulty with walking and Activities of Daily Living (ADLs)

    - Prior to surgery, Individual's weight has been addressed, as indicated by stable weight for at least 3 months
- **Surgical removal of keloids** after the failure of conservative non-surgical therapies (including but not limited to corticosteroids, pressure dressing, etc.) and **1 or more** of the following:
    - Significant pain
    - Bleeding
    - Infection

In the event an individual is requesting a repeat or correction to a previous procedure undergone for **non-covered cosmetic/plastic surgery** with subsequent physical complication (ie. Infection, adhesions, chronic pain, slow-healing wounds and incisions, tissue necrosis) refer to **member benefit** by the Medical director on a **case-by-case basis.**

Cosmetic/plastic surgery is considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Abdominal lipectomy (when done independently and not part of an approved panniculectomy procedure)
- Abdominoplasty
- Any procedure for photo-aged skin, wrinkles
- Buttock lift or augmentation
- Cervicoplasty
- Chemical exfoliation for acne and all other indications
- Chemical Peels for Acne scarring, Active Acne Vulgaris, Photoaged skin, Uneven epidermal pigmentation or Wrinkles
- Circumferential Body Lift
- Correction of diastasis recti abdominis
- Cryotherapy (CO_2 slush, liquid N_2) for acne
- Dermabrasion for post-acne scarring, for tattoos
- Diastasis recti repair
- 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
- For Improvement of a member's appearance or self-esteem whether or not for psychological or emotional reasons
- Implants including malar and chin
- Inverted nipple or correction of inverted nipple
- Lipectomies
    - Abdominal lipectomy (when done independently and not part of an approved panniculectomy procedure)
    - Belt Lipectomy
    - Circumferential Lipectomy
    - Suction assisted lipectomy & Suction Lipectomy
- Lipo-abdominoplasty
- Liposuction
- Lower Body Lift
- Mesotherapy (injection of various substances into the tissue beneath the skin to sculpt body contours by lysing subcutaneous fat)
- Mommy makeovers
- Neck tucks
- Removal of frown lines
- Removal of supernumerary nipples (polymastia)
- Repair of diastasis recti
- Repair of nasal valve collapse with low energy, temperature-controlled (i.e., radiofrequency) subcutaneous/submucosal remodeling) (also known as VivAer)
- Restoration of an anatomical defect that does not significantly affect functioning
- Salabrasion-for tattoo removal-cosmetic

- 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
- Torsoplasty
- Umbilicus repair
- Vaginal rejuvenation procedures (designer vaginoplasty, revirgination, G-spot amplification, reduction of labia minora)

Dermatologic Conditions (treatments, removal, laser therapy, dermoscopy or biopsy) are considered contraindicated and/or not medically necessary for any use other than those indicated in clinical criteria, to include but not limited to:

- Destruction of cutaneous or intraneural neurofibroma (more than 50 on the face, head, and neck, or more than 100 on the trunk and extremities**) 0419T, 0420T**
- Keloids that result from a cosmetic procedure such as body piercing

Document History:

Revised Dates:

- 2026: June – Implementation date of October 1, 2026. Addition of criteria for Nasal Repair, Surgical 230 (Archived) and codes to policy.
- 2026: May – Annual review of Dermatologic Conditions Surgical 09. Archiving policy and add remaining criteria to this policy.
- 2026: January – Implementation date of May 1, 2026. Annual review completed. No criteria changes, coding updated to align with auth changes.
- 2025: March – Implementation date of 6.1.2025. Revision of criteria and housekeeping
- 2025: January – Procedure codes updated to align
- 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

Origination Date: May 1991

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)
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
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
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implants(s)
30999	Unlisted procedure, nose
L8699	Prosthetic implant, not otherwise specified

Considered Not Medically Necessary:

Coding	Description
0419T	Destruction neurofibroma, extensive, (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibromas
0420T	Destruction neurofibroma, extensive, (cutaneous, dermal extending into subcutaneous); trunk and extremities, extensive, greater than 100 neurofibromas
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)
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
30469	Repair of nasal valve collapse with low energy, temperature-controlled (i.e., radiofrequency) subcutaneous/submucosal remodeling)
69300	Otoplasty, protruding ear, with or without size reduction
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Policy Approach and Special Notes: *

- Coverage:
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products:
  - Policy is applicable to Sentara Health Plan Virginia Medicaid products.
  - See MCG Photodynamic Therapy, Skin (A-0254) – CPT 96567, 96573, 96574
- Authorization requirements:
  - Pre-certification by the Plan is required.
  - **Please refer to Prior Authorization List for most up to date requirement Search PAL List: Sentara Health Plans**
- 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 by medically necessary to correct or ameliorate the member's condition. EPSDT Supplement B (updated 5.19.22)_Final.pdf.
- Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

References:

References used include but are not limited to the following: 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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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