MEDICAL POLICY

Capital BLUE

POLICY TITLE	COSMETIC AND RECONSTRUCTIVE SURGERY
POLICY NUMBER	MP-1.004

Original Issue Date (Created):	**7/1/2002**
Most Recent Review Date (Revised):	**9/12/2018**
Effective Date:	**11/1/2018**

I. POLICY

Surgery to correct developmental or other physical feature abnormalities is considered reconstructive only if a functional impairment exists. In the absence of functional impairment, the procedure is cosmetic. In order for such services to be considered medically necessary, there must be clear and unequivocal documentation in the medical record to support the reconstructive nature of the services.

The following services are considered **medically necessary** only when performed for the specified diagnosis:

- Dermal chemical peels used to treat patients with numerous (greater than 10) actinic keratoses or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical, may be considered medically necessary.
- Epidermal chemical peels used to treat patients with active acne that has failed a trial of topical and/or oral antibiotic acne therapy are considered medically necessary. In this setting, superficial chemical peels with 50–70% alpha hydroxy acids are used as a comedolytic therapy. (Alpha hydroxy acids can also be used in lower concentrations [8%] without the supervision of a physician.)
- Earlobe surgery to repair a “through and through” laceration resulting in a bilobe earlobe;
- Hair removal to prevent the recurrence of pilonidal cysts or when ingrown hairs are responsible for repeated painful cysts;
  Lipectomy and liposuction for the excision of excess skin and/or subcutaneous fat where there is documented clinical evidence that the presence of this excess tissue has resulted in the following with failure to respond to conventional treatment:
  - Other significant functional impairment; or
  - Severe symptomatic conditions including, but not limited to, chronic pain, dermatitis or skin ulcerations.

- Liposuction for posttraumatic soft tissue deformity, post traumatic lipoma and medication induced lipodystrophy;
- Mohs micrographic surgery (MMS) for the following indications:
  - Basal cell carcinomas and squamous cell carcinomas, malignant melanomas* or other skin cancer with malignant potential.

  * Malignant melanoma margins in any area are difficult to determine in frozen sections, as is done with MMS. Only in exceptional circumstances should MMS be performed for such lesions. It should be carefully documented in the medical records why MMS was medically necessary.

  The accepted standard of care is to perform Mohs excision and closure on the same day. Medical necessity for delayed closure may be supported by the following:

    - Delay for granulation formation to facilitate flap/graft success, or
    - Patient was unable to continue with closure on the same day due to physical or psychological discomfort, or
    - Due to surgical requirements for large amounts of local anesthesia, patient requires delayed closure to metabolize the anesthesia
- Otoplasty when performed to correct functional hearing impairment (i.e., inability to hear normal conversation); and
- Rhytidectomy when performed for the correction of a disease state that has caused irreversible facial paralysis or in the treatment of disfiguring burns of the head and neck region; and
- Scar revision for the correction of post-infective, post-surgical or keloid scars when accompanied by functional impairment;
- Scar revision for post-traumatic scars due to accidental injury, (Note: prior surgery is not considered accidental injury); and
- Surgical excision or incision and drainage of cysts for the treatment of severe cystic acne. Surgical repair of symptomatic pectus excavatum may be considered medically necessary in patients demonstrating functional impairment by meeting ALL of the following criteria:

  - Chest wall index (pectus index) greater than 3.25 (derived from dividing the transverse diameter of the chest by the anterior-posterior diameter), as evidenced by CT scan; and
  - Cardiopulmonary impairment (such as decreased cardiac output and/or abnormal pulmonary function during exercise atypical chest pain, asthma, or frequent lower respiratory tract infections); and
- For known heart murmur or disease, definition of the relationship of the cardiac problem to the sternal deformity as evidenced by electrocardiogram or echocardiogram; and

- A cardiologist or pulmonologist concurs with the need for surgical correction

Surgical repair of pectus excavatum for asymptomatic patients or in patients not meeting the criteria listed in the guidelines is considered **not medically necessary**.

Rhinoplasty, Septoplasty, Septorhinoplasty

Rhinoplasty, Septoplasty or Septorhinoplasty when performed in association with cleft lip and/or cleft palate repair is considered **medically necessary** to correct the congenital defect.

All other requests for septoplasty, rhinoplasty, or septorhinoplasty must include the following:

- Results of any clinically indicated diagnostic studies to document the deformity and/or obstruction including the following:
  - CT scanor any other appropriate imaging modality
  - Nasal endoscopy
- Documented severity and duration of symptoms caused by the deformity and/or obstruction
- Documented relevant history of trauma, disease, or congenital defect

Septoplasty

Septoplasty is considered **medically necessary** when used to treat a septal deformity resulting in any of the following conditions:

- Continuous nasal airway obstruction when both of the following criteria are met:
  - There is documentation of nasal airway restriction and
  - A recent eight week trial of conservative medical therapy (e.g., decongestants, nasal spray, corticosteroids) has been ineffective in treating the obstruction, which can only be corrected by surgery.
- Recurrent sinusitis felt to be due to a deviated septum documented by ALL of the following
  - four or more episodes of acute sinusitis per year treated with antibiotics and/or other medications,
  - each episode lasting more than seven days, with an absence of symptoms between episodes (without antibiotic therapy)
  - septum touching the middle turbinate or septum blocking the middle meatus
- Recurrent epistaxis (i.e., nose bleed) related to septal deformity
- Obstructed nasal breathing interfering with effective use of medically necessary continuous positive airway pressure (CPAP) for the treatment of obstructive sleep disorder when a recent four week trial of conservative medical therapy (e.g., decongestants, nasal spray, corticosteroids) has been ineffective in treating the obstruction, which can only be corrected by surgery.

Septoplasty for indications not meeting the criteria listed above is considered **cosmetic** and **not medically necessary**.

Rhinoplasty

Rhinoplasty to correct chronic non-septal nasal airway obstruction from vestibular stenosis (collapsed internal valves) due to trauma, extensive nasal disease, or congenital defect may be considered **medically necessary** when ALL of the following criteria are met:

- Physical examination confirming moderate to severe functional nasal obstruction (positive Cottle maneuver) from a structural abnormality
- Airway obstruction will not respond to septoplasty and/or turbinectomy alone.
- There is significant obstruction of one or both nares and
  Documentation includes:
    - Duration and degree of symptoms related to nasal obstruction *and*
    - Results of conservative management of symptoms; *and*
    - Relevant history of accidental or surgical trauma, congenital defect, or disease (e.g., Wegener's granulomatosis, choanal atresia, nasal malignancy, abscess, septal infection with saddle deformity, or congenital deformity)

Rhinoplasty for indications not meeting the criteria listed above is considered **cosmetic** and **not medically necessary.**

Epidermal chemical peels used to treat photoaged skin, wrinkles, or acne scarring or dermal peels used to treat end-state acne scarring are considered **cosmetic** and **not medically necessary.**

The surgical treatment (e.g., marsupialization, opening, expression) of comedones, or milia, and pustules is considered **cosmetic.**

Cross-references:

- MP-1.012 Abdominoplasty and Panniculectomy
- MP-1.002 Augmentation Mammoplasty
- MP-1.003 Blepharoplasty, Repair of Brow Ptosis and Reconstructive Eyelid Surgery
- MP-2.006 Botulinum Toxin
- MP-1.008 Laser Treatment of Port Wine Stains
- MP-1.101 Orthognathic Surgery
- MP-1.013 Reduction Mammoplasty for Breast-Related Symptoms
- MP-1.103 Reconstructive Breast Surgery/Management of Breast Implants
- MP-1.144 Gender Reassignment Surgery for Gender Dysphoria
- MP-2.071 Rosacea
- MP-1.061 Treatment of Varicose Veins/Venous Insufficiency

- MP-1.015 Bariatric Surgery

II. PRODUCT VARIATIONS

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This policy is applicable to all programs and products administered by Capital BlueCross unless otherwise indicated below.

FEP PPO: Benefits are excluded for cosmetic surgical procedures. This includes any surgical procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury, or to restore or correct a part of the body that has been altered as a result of disease or surgery or to correct a congenital anomaly.

Reconstructive surgery is a covered benefit and includes the following:

- Surgery to correct a functional defect
- Surgery to correct a condition caused by injury or illness if the condition produced a major effect on the member's appearance and the condition can reasonably be expected to be corrected by such surgery
- Surgery to correct a congenital anomaly, a condition that existed at or from birth and is a significant deviation from the common form or norm (Examples: protruding ear deformities, cleft lip, cleft palate, birth marks, webbed fingers, webbed toes)
- All stages of breast reconstruction surgery following a mastectomy
- Treatment to restore the mouth to a pre-cancer state
- Surgery for placement of penile prostheses to treat erectile dysfunction

Note: prior approval for outpatient surgical correction of congenital anomalies is required. Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth

For chemical peels refer to FEP Medical Policy Manual MP-8.01.16 Chemical Peels.The FEP Medical Policy manual can be found at: https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies

CHIP (aka Capital Cares 4Kids): Benefits are excluded for Cosmetic *surgery* or other procedures to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons, and from which no improvement in physiological function can be expected, except for *surgery* or services which are required by law or as specified in the covered *benefits* section listed in the member handbook. Cosmetic Procedure is defined as a medical or surgical procedure which is performed to improve the appearance of any portion of the body and from which no improvement in physiologic function may be expected
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Special Care: Excluded are drugs, services and operations for cosmetic purposes used or performed to improve the appearance of any portion of the body and from which no significant improvement in physiologic function can be expected, except as otherwise required by law. This exclusion does not apply to drugs, services and operations for cosmetic purposes necessitated by a covered sickness or injury or procedure to improve or correct a functional impairment, restore bodily function or correct deformity resulting from birth defect, disease or accidental injury

III. DESCRIPTION/BACKGROUND TOP

This policy documents the criteria that distinguish cosmetic from reconstructive surgical services.

IV. RATIONALE TOP

NA

V. DEFINITIONS TOP

BASIC ACTIVITIES OF DAILY LIVING include and are limited to walking in the home, eating bathing, dressing, and homemaking**.**

BIRTH DEFECT- refers to an internal or external congenital abnormality that is present at birth that does not develop, appear, or manifest itself later in life.

COSMETIC SURGERY: An elective procedure performed primarily to restore a person's appearance by surgically altering a physical characteristic that does not prohibit normal function, but is considered unpleasant or unsightly.

FUNCTIONAL IMPAIRMENT is a condition that describes a state where an individual is limited in the performance of basic activities of daily living.

KELOID refers to an overgrowth of collagenous tissue at the site of a skin injury, particularly a wound or surgical incision. The new tissue is elevated, rounded and firm.

LIPOMA is a benign fatty tumor. It is frequently found in multiple sites but is not metastatic.

RECONSTRUCTIVE SURGERY: A procedure performed to improve or correct a functional impairment, restore a bodily function or correct a deformity resulting from birth defect or accidental injury. The fact that a member might suffer psychological consequences from a deformity does not, in the absence of bodily functional impairment, qualify surgery as being reconstructive surgery

VI. BENEFIT VARIATIONS TOP

The existence of this medical policy does not mean that this service is a covered benefit under the member's contract. Benefit determinations should be based in all cases on the applicable contract language. Medical policies do not constitute a description of benefits. A member's individual or group customer benefits govern which services are covered, which are excluded, and which are subject to benefit limits and which require preauthorization. Members and

providers should consult the member's benefit information or contact Capital BlueCross for benefit information.

VII. DISCLAIMER

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Capital BlueCross's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. Capital BlueCross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

The following are cosmetic; therefore, not covered:

CPT Codes®								
0419T	0420T	17340	69090					

HCPCS Code	Description
Q2026	Injection, Radiesse, 0.1 ml
Q2028	Injection, sculptra, 0.5 mg

Covered when medically necessary:

CPT Codes®								
10040	15780	15781	15782	15783	15786	15788	15789	15792
15793	15824	15825	15826	15828	15829	15830	15832	15833
15834	15835	15836	15837	15838	15839	15847	15876	15877
15878	15879	17000	17003	17004	17110	17111	17311	17312
17314	17315	17360	17380	21740	21742	21743	30400	30410
30420	30430	30435	30450	30460	30462	69300		

IX. REFERENCES

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Otoplasty

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Septoplasty, Rhinoplasty

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X. POLICY HISTORY

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MP 1.004	**CAC 4/27/04**
	CAC 6/29/04
	CAC 12/14/04
	CAC 11/29/05
	CAC 11/28/06
	CAC 4/24/07
	CAC 11/27/07
	CAC 7/29/08
	J12 MAC 12/12/08
	CAC 11/24/09 Medical necessity for scar revision wording revised. Medicare variation added for coverage of skin lesions. Additional exclusion statement added related to cosmetic procedures and services. Special Care product variation added.
	CAC 9/27/10 Dermal injection procedure and measuring the marker for skin aging were added to the policy: considered cosmetic for Commercial; dermal injection for HIV treatment complications added as a variation for Medicare. Medical necessity for skin tags was removed to match 10/1/10 benefit changes.
	CAC 4/26/11 Information and criteria related to excluded procedures removed from the policy.
	CAC 6/26/12 Consensus review; no changes, references updated. FEP variation updated for reconstructive surgery.
	10/29/12 Administrative change to correct formatting. Special Care and Capital Cares 4 Kids benefit variations updated.

POLICY TITLE	COSMETIC AND RECONSTRUCTIVE SURGERY
POLICY NUMBER	MP-1.004

	CAC 1/29/13 Minor review. Deleted functional impairment as a requirement for scar revision related to accidental injury to be consistent with COC. Deleted statement "Medical complications resulting from a non-covered service will be covered". Removed rhinoplasty codes 11/12/12.
	1/3/13 Preauthorization Committee no longer requires preauth for cleft lip/palate repair. Provider notification will be required.
	1/7/13 Rhinoplasty codes added
	1/8/13- Lipectomy codes added
	1/31/2013-Cleft palate codes removed from policy
	CAC 7/30/13 Minor revision. Added medically necessary indications for dermal and epidermal chemical peels for acne, actinic keratoses and other pre-malignant skin lesions and the surgical excision or incision and drainage of cysts for the treatment of severe cystic acne. References updated. Admin code review complete. Also added the following statements: Epidermal chemical peels used to treat photoaged skin, wrinkles, or acne scarring or dermal peels used to treat end-state acne scarring are considered cosmetic and not medically necessary and the surgical treatment (e.g., marsupialization, opening, expression) of comedones, or milia, and pustules is considered cosmetic.
	12/20/2013- New 2014 Code updates made.
	5/20/14 Consensus – no change to policy statements. References updated. Codes reviewed.
	11/2/15 Administrative change. LCD numbers changed from L27503 and L27527 to L35069 and L34938 due to Novitas update to ICD-10.
	CAC 7/21/15 CAC Minor, added- The accepted standard of care is to perform Mohs excision and closure on the same day. Medical necessity for delayed closure may be supported by the following: • Delay for granulation formation to facilitate flap/graft success, or • Patient was unable to continue with closure on the same day due to physical or psychological discomfort, or • Due to surgical requirements for large amounts of local anesthesia, patient requires delayed closure to metabolize the anesthesia L35069 to change to L34961 effective 12/31/15. Coding corrected
	Administrative 2/4/16: 2016 coding update (0419T, 0420T)
	CAC 7/26/16 Consensus. No change to policy statements. References reviewed. Coding reviewed.
	Admin update 1/1/17: Product variation section reformatted. Added new codes 31574, 31591 as well as replacement code G0429 and removed end dated code C9800; effective 1/1/17.
	1/1/18 Admin Update: Medicare variations removed from Commercial Policies

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	12/19/17 Minor review. Added policy statements addressing rhinoplasty, septoplasty and pectus excavatum. Coding reviewed and changes completed. Effective 4/1/18.
	9/12/18 Consensus review. No change to the policy statements. References reviewed**.** Coding reviewed.

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