Capital

MEDICAL POLICY

POLICY TITLE	COSMETIC AND RECONSTRUCTIVE SURGERY
POLICY NUMBER	MP 1.004

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☒ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	4/1/2024

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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 may be considered **medically necessary** only when performed for the specified diagnosis:

- Dermal chemical peels used to treat individuals with numerous (greater than 10) actinic keratoses or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical;
- Epidermal chemical peels used to treat individuals 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 40–70% 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 (lipedema) 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
  - Individual 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, individual requires delayed closure to metabolize the anesthesia
- Otoplasty when performed to correct functional hearing impairment (i.e., inability to hear normal conversation);
- 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;
- 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);
- Surgical excision or incision and drainage of cysts for the treatment of severe cystic acne;
- Surgical repair of symptomatic pectus excavatum in individuals 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.

Epidermal chemical peels used to treat photo aged 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 and **not medically necessary.**

Dermal fillers are considered cosmetic and **not medically necessary.**

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

Grafting of autologous fat for indications other than the medically necessary criteria outlined in **MP 1.002** Augmentation Mammoplasty is considered cosmetic and **not medically necessary.**

Septoplasty, Rhinoplasty, Septorhinoplasty

Septoplasty, rhinoplasty, or septorhinoplasty when performed in association with cleft lip and/or cleft palate repair may be 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 scan or 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

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; and
- Airway obstruction will not respond to septoplasty and/or turbinectomy alone; and
- 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)

A secondary rhinoplasty (corrective nasal surgery after first rhinoplasty) may be considered **medically necessary** if symptoms continue or are made worse by the primary procedure. All criteria above for the primary rhinoplasty must be met.

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

Septoplasty

Septoplasty may be 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; and
  - Each episode lasting more than seven days, with an absence of symptoms between episodes (without antibiotic therapy); and
  - 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.

A secondary septoplasty (corrective nasal surgery after first septoplasty) may be considered **medically necessary** if symptoms continue or are made worse by the primary procedure. All criteria above for the primary septoplasty must be met.

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

Cross-references:

MP 1.002 Augmentation Mammoplasty
MP 1.003 Blepharoplasty, Repair of Brow Ptosis, and Reconstructive Eyelid Surgery
MP 1.008 Laser Treatment of Port Wine Stains
MP 1.012 Abdominoplasty and Panniculectomy
MP 1.013 Reduction Mammoplasty for Breast-Related Symptoms
MP 1.015 Bariatric Surgery
MP 1.061 Treatment of Varicose Veins/Venous Insufficiency
MP 1.101 Orthognathic Surgery
MP 1.103 Reconstructive Breast Surgery/Management of Breast Implants
MP 1.144 Gender Affirming Surgery (Formerly Gender Reassignment Surgery for Gender Dysphoria)
MP 2.071 Rosacea

II. PRODUCT VARIATIONS TOP

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

FEP PPO - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at: https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies

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 health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits and which require preauthorization. There are

different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER TOP

Capital Blue Cross'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. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION TOP

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:

Procedure Codes								
J0591	Q2026	Q2028	0419T	0420T	15771	15772	15773	15774
17340	69090							

Covered when medically necessary:

Procedure 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	30520	69300	0479T
0480T								

IX. REFERENCES TOP

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X. POLICY HISTORY

TOP

MP 1.004	
	6/1/20 Administrative update. Code J0591 added per new code review. Product, Benefit, and Disclaimer updated.
	8/20/20 Minor review. Policy statement revised. Language for secondary septoplasty and rhinoplasty added. Added, "dermal fillers are considered cosmetic and therefore not medically necessary". Added "grafting of autologous fat for indications other than the medically necessary criteria outlined in MP 1.002, Augmentation Mammoplasty, is considered cosmetic and therefore not medically necessary". Coding updated: CPT 30520 added (covered when medically necessary); 15773 and 15774 added (cosmetic). References updated.
	7/30/2021 Minor review. Removal of "a cardiologist or pulmonologist concurs with the need for surgical correction" from guidelines for pectus excavatum. References reviewed and updated. Added codes 15771 and 15772 to not covered.
	1/5/2022 Consensus review. No change to policy statement. References reviewed and updated. Cross-references updated. Product Variations updated.
	10/5/2023 Administrative review. Added 0479T and 0480T to MN coding table.
	12/29/2023 Consensus Review. No change to policy statement. Reformatting for clarity, updated references.

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