Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

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***Current Policy Effective Date: 5/1/21**
(See policy history boxes for previous effective dates)

Title: Cosmetic and Reconstructive Surgery

Description/Background

Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, involutional defects, tumors or disease. It is generally performed to improve function but may also be done to approximate a normal appearance following trauma or disease or when due to a congenital malformation.

The definition of “reconstructive” may be based on two distinct factors:

- The procedure is primarily intended to improve/restore bodily function or to correct significant deformity resulting from accidental injury, trauma, or previous therapeutic process
- The procedure is intended to correct congenital or developmental anomalies that have resulted in significant functional impairment.

The presence or absence of a functional impairment is a critical element in the consideration of medical necessity for the surgery. There are certain scenarios wherein reconstructive services may be considered medically necessary even though these services are designed to restore the normal appearance of the patient, rather than correct a functional impairment. This would support a concept of reconstructive services as returning the patient to "whole" after surgery or trauma (e.g., breast reconstructive surgery following mastectomy).

For musculoskeletal conditions, the concept of a functional impairment is straightforward. However, when considering dermatologic conditions, the function of the skin is more difficult to define. Procedures designed to enhance the appearance of the skin are typically considered cosmetic, but some dermatologic conditions may significantly alter the function of the skin; one example is pemphigus, which impairs the fluid balance of the body.

Medical Policy Statement

Reconstructive surgery is an established service when it involves the restoration of a patient to a normal functional status, or when it is done to repair a defect arising from congenital defects, developmental abnormalities, trauma, infection, involutional defects, tumors or disease. It may be a therapeutic option when indicated.

Cosmetic surgery is performed solely to preserve or enhance appearance or self-esteem. It is considered not medically necessary.

Inclusionary and Exclusionary Guidelines (Clinically based guidelines that may support individual consideration and pre-authorization decisions)

In the absence of a *functional* deficit, reconstructive surgery may be used to restore a patient's appearance to the state of normalcy that existed prior to the illness, traumatic injury or surgery.

Declaration of medical necessity to justify surgery should be supported by medical documentation. Categories of conditions that may be included as part of the contractual definition of reconstructive services include the following:

- Post-surgery (including breast reconstruction)
- Accidental trauma or injury
- Diseases
- Congenital anomalies
- Post-chemotherapy
- Massive weight loss causing functional impairment, including but not limited to, severe rashes or intertrigo, skin ulceration or pain (such as backache due to a large panniculus), etc. that has not responded to conventional therapy.

The following procedures may be considered either cosmetic or reconstructive in nature based on the indications for the surgery. (NOTE: this list is not all-inclusive):

Procedure	Cosmetic vs. Reconstructive
Abdominoplasty / Panniculectomy	• *Reconstructive* if patient meets policy guidelines. See joint policy, "Abdominoplasty,"
Blepharoplasty of lower lids	• *Cosmetic*
Blepharoplasty of upper lids	• *Cosmetic* when done to improve appearance only. • *Reconstructive* if criteria are met. Refer to policy "Blepharoplasty and Repair of Brow Ptosis."
*Breast augmentation / reconstruction	• *Cosmetic* if done solely to improve appearance • *Reconstructive* if done following prophylactic mastectomy in high-risk patients. May also be considered reconstructive following medically necessary mastectomy. This would include reconstruction of the nipple and areolar complex. Reconstruction/revision of the contralateral breast may be necessary to provide symmetry between the breasts. • *See medical policy titled "Reconstructive Breast Surgery/Management of Breast Implants" for tattooing the breast/nipple in conjunction with breast reconstruction.

Breast reduction	• *Cosmetic* if done to improve appearance in the absence of functional deficits • *Reconstructive* if policy guidelines are met. See joint policy, "Reduction Mammoplasty for Breast-Related Symptoms."
*Chemical peels	• *Cosmetic* when done for aging skin (e.g., skin damage due to overexposure to sun, etc.), wrinkles, acne scarring, or when using chemical peel and hydrating agents that do not require physician supervision for application • *Reconstructive* when guidelines are met: Chemical peels performed no more than three to four times in a 12-month period are appropriate as follows: – Dermal (medium and deep) chemical peels, up to four times per in a 12 month period, used to treat patients with numerous (>10) actinic keratoses or other premalignant skin lesions – Epidermal (superficial) peels, up to six times in a 12 month period, to treat active acne in patients who have failed other therapy ***Note:** Requests for chemical peels should be carefully evaluated to determine if the request is primarily cosmetic in nature. Refer to joint policy, "Chemical Peels."
Cheek (malar) or chin (genioplasty) implants	• *Cosmetic*
Correction of telangiectasias or spider veins	• *Cosmetic*
Cryotherapy for skin conditions	• *Cosmetic* when used to treat acne scarring or other dermatologic conditions in which the primary purpose is to change or improve appearance when there is no specific functional deficit or imminent health risk. Cryotherapy is not recommended for the treatment of active acne vulgaris. • *Reconstructive* when used to treat actinic keratosis or other pre-cancerous skin lesions
Dermabrasion/ microdermabrasion	• *Cosmetic* when used for treatment of wrinkling, hyperpigmentation, or acne scarring. Dermabrasion and microdermabrasion are not recommended for the treatment of active acne vulgaris. • *Reconstructive* when used to treat actinic keratosis or other pre-cancerous skin lesions
Dermal fillers	• *Cosmetic*-only used to improve appearance.
Diastasis recti repair absent a true midline hernia	• *Cosmetic*
Electrolysis	• *Cosmetic*

Excision of excessive skin of the thigh, leg, hip, buttock,	• *Cosmetic* if the primary purpose is to change or improve appearance when there is no specific functional deficit

arm, forearm, hand, submental fat pad or other areas	(e.g., interference with ADLs) or imminent health risk (e.g. infection) that can be removed or improved by the procedure. • *Reconstructive* if done to correct a functional problem, including but not limited to severe rashes or intertrigo, skin ulceration or pain, etc. that has not responded to conventional medical therapy (e.g. topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics).
Excision of glabellar frown lines	• *Cosmetic*
Fat grafts	• *Cosmetic*
Hairplasty for any form of alopecia	• *Cosmetic*; Coverage may be available only for the treatment of the underlying condition only.
Insertion or injection of prosthetic material to replace absent adipose tissue	• *Reconstructive* only when used to repair a significant deformity from accidental injury, surgery or trauma.
Laser resurfacing of the skin	• *Cosmetic* when done to treat wrinkling or aging skin, acne scars, telangiectasias, or other skin conditions in which the primary purpose is to change or improve appearance when there is no specific functional deficit or imminent health risk. Laser resurfacing is not recommended for the treatment of active acne vulgaris. • *Reconstructive* when done to treat patients with numerous (>10) actinic keratoses or other pre-malignant or nonmalignant skin lesions when treatment of the individual lesions would be impractical.
Laser Resurfacing of burn scars (ablative/non-ablative fractional and micro-fractional CO_2 laser resurfacing)	• *Reconstructive* when used to help correct the abnormal texture and pliability of burn scars
Laser treatment of port wine stains	• *Reconstructive* if done due to functional impairment related to the port wine stain (e.g., bleeding).
Liposuction / suction-assisted lipectomy	• *Cosmetic* if it is the sole procedure done. o Commonly performed on the abdomen (the "tummy"), buttocks ("behind"), hips, thighs and knees, chin, upper arms, back and calves. o Long term effectiveness of treatment of lower extremity lymphedema has not been established • *Reconstructive* if done in conjunction with covered reconstruction surgery. For example, if a covered breast reduction is done by conventional means, there may be a need for minor liposuction to smooth the edges of the incisions.

Otoplasty	• *Cosmetic* when done to treat psychological symptomatology or psychosocial complaints related to

	one's appearance • *Reconstructive* in following circumstances: when done to correct absent or deformed ears due to congenital deformity/absence, trauma or accidental injury.
Poly-L-lactic acid injection (e.g., Sculptra®)	• *Cosmetic* for all indications, including HIV lipoatrophy
Reduction of labia majora and minora, or labiaplasty	• *Cosmetic.* In situations where there is discomfort from the condition, these symptoms can be managed with personal hygiene and avoidance of form-fitting clothes.
Rhinoplasty	• *Cosmetic* if done to improve appearance only. • *Reconstructive* if done for repair of nasal deformity due to trauma, accidental injury, or chronic condition affecting the nasal structures (e.g. Wegener's granulomatosis).
Salabrasion (a technique in which salt or a salt solution is used to abrade the skin, e.g. to remove the pigment from a tattoo or permanent makeup)	• *Cosmetic*
Scar revision	• *Cosmetic* if scars are asymptomatic • *Reconstructive* for the revision of symptomatic scars
Tattoo removal	• *Cosmetic* if done for the removal of decorative tattoos • *Reconstructive* if done for the removal of hyperpigmentation resulting from trauma, surgery or other procedures
Testicular prostheses	• *Reconstructive* for replacement of congenitally absent testes, or testes lost due to disease, injury, or surgery.
Voice lifting procedures (e.g., Restylane injections)	• *Cosmetic.* Implants or injections of fat or collagen are used to bring vocal cords closer together or to plump cords in an attempt to restore elasticity of vocal cords and reinstate a youthful quality to the patients voice.

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

Established codes:

Multiple

Rationale

The American Society of Plastic Surgeons (ASPS) defines cosmetic plastic surgery as "surgical and nonsurgical procedures that enhance and reshape structures of the body to improve appearance and confidence." Additionally, the ASPS states that "reconstructive surgery is performed to treat structures of the body affected aesthetically or functionally by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function and ability, but may also be performed to achieve a more typical appearance of the affected structure." Reconstructive surgery is intended to restore the functional status of a patient.

The references listed in this policy reflect the current standards of care and support the inclusions and exclusions of the procedures noted.

Government Regulations
NCD:

"Breast Reconstruction Following Mastectomy" (140.2); Pub Number 100-3; V.1, Effective Date: 11/1/1997

Indications and Limitations of Coverage
Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered a relatively safe and effective noncosmetic procedure. Accordingly, program payment may be made for breast reconstruction surgery following removal of a breast for any medical reason.

Program payment may not be made for breast reconstruction for **COSMETIC** reasons. (**COSMETIC** surgery is excluded from coverage under §l862(a)(l0) of the Act.)

"Laser Procedures" (140.5); Pub Number 100-3; V.1, Effective Date: 5/1/97

Indications and Limitations of Coverage
Medicare recognizes the use of lasers for many medical indications. Procedures performed with lasers are sometimes used in place of more conventional techniques. In the absence of a specific noncoverage instruction, and where a laser has been approved for marketing by the Food and Drug Administration, Medicare Administrative Contractor discretion may be used to determine whether a procedure performed with a laser is reasonable and necessary and, therefore, covered.

The determination of coverage for a procedure performed using a laser is made on the basis that the use of lasers to alter, revise, or destroy tissue is a surgical procedure. Therefore, coverage of laser procedures is restricted to practitioners with training in the surgical management of the disease or condition being treated.

Plastic Surgery to Correct "Moon Face" (140.4) Pub Number 100-3; V.1, Effective Date: 5/1/89

Indications and Limitations of Coverage
The **COSMETIC** surgery exclusion precludes payment for any surgical procedure directed at improving appearance. The condition giving rise to the patient's preoperative appearance is generally not a consideration. The only exception to the exclusion is surgery for the prompt repair of an accidental injury or for the improvement of a malformed body member which coincidentally serves some **COSMETIC** purpose. Since surgery to correct a condition of "moon face" which developed as a side effect of cortisone therapy does not meet the exception to the exclusion, it is not covered under Medicare (§1862(a)(10) of the Act).

Local:

"Blepharoplasty, Blepharoptosis and Brow Lift" (L34528) for services performed on or after 4/30/20:

Coverage Indications, Limitations, and/or Medical Necessity
Blepharoplasty, blepharoptosis and lid reconstruction may be defined as any eyelid surgery that improves abnormal function, reconstructs deformities, or enhances appearance. They may be either functional/reconstructive or cosmetic. Upper blepharoplasty (removal of upper eyelid skin) and/or repair of blepharoptosis should be considered functional/reconstructive in nature when the upper lid position or overhanging skin or brow is sufficiently low to produce functional complaints, usually related to visual field impairment whether in primary gaze or down-gaze reading position. Upper blepharoplasty may also be indicated for chronic dermatitis due to redundant skin. Another indication for blepharoptosis surgery is patients with an anophthalmic socket experiencing ptosis or prosthesis difficulties. Brow ptosis (i.e., descent or droop of the eyebrows) can also produce or contribute to functional impairment.

The criteria in section A (patient signs and symptoms), section B (photographs), and section C (visual field) below must be documented to demonstrate medical necessity.

A. Documentation in the medical records must include patient complaints and findings secondary to eyelid or brow malposition such as:
   1. Interference with vision or visual field, related to activities such as, difficulty reading due to upper eyelid drooping, looking through the eyelashes, seeing the upper eyelid skin, or brow fatigue.
   2. Chronic eyelid dermatitis due to redundant skin.
   3. Difficulty wearing prosthesis, artificial eye.
   4. Margin reflex distance (MRD) of 2.5 mm or less.
      (The margin reflex distance is a measurement from the corneal light reflex to the upper eyelid margin with the brows relaxed.)
   5. A palpebral fissure height on down-gaze of 1 mm or less.
      (The down-gaze palpebral fissure height is measured with the patient fixating on an object in down-gaze with the ipsilateral brow relaxed and the contralateral lid elevated.)
   6. The presence of Herring's effect meeting one of the above two (#4 or 5) criteria.
      (Herring's law is one of equal innervation to both upper eyelids and is considered in the documentation to perform bilateral ptosis in which the position of one upper eyelid has marginal criteria and the other eyelid has good supportive documentation for ptosis surgery. In these cases, the surgeon can lift the more ptotic lid with tape or instillation of Phenylepherine drops into the superior formix. If the less ptotic lid then drops downward according to Herring's law to the point of an MRD of 2.5 mm or less or a down-gaze MRD of 1.5 or less or a palpebral fissure width on down-gaze of 1 mm or less, then the less ptotic lid would be considered for surgical correction.)

B. Photographs and medical record documentation must demonstrate at least one of the following: (Digital or film photographs are acceptable.)
   1. For Blepharoptosis Repair: Photographs of both eyelids in the frontal, straight-ahead position and/or down-gaze should be taken as appropriate.
   2. For Blepharoplasty Repair: Frontal photos are needed to demonstrate redundant skin on the upper eyelids.
      a. Upper eyelid skin resting on the eyelashes or over eyelid margin
      b. Upper eyelid dermatitis secondary to redundant skin
      c. Dermatochalasis
   3. For Brow Ptosis Repair: Photographs should document medical necessity for brow ptosis repair (drooping of brows). Frontal photographs are necessary.

4. For a combination of any of the above procedures (blepharoptosis repair, blepharoplasty repair and brow ptosis repair): the medical necessity criteria for each procedure must be met and the additional criteria of lateral and full-face photographs with attempts at brow elevation and upward gaze (i.e., with the brow relaxed) must also be met.

C. Visual fields
1. The indication for surgery is supported if a difference of 12º or more or 30% superior visual field difference is demonstrated between visual field testing before and after manual elevation of the eyelids.
2. Visually significant brow ptosis may be documented by visual field testing with the brow elevated demonstrating a difference of 12º or more or 30% superior visual field difference.
3. Visual fields need to meet accepted quality standards, whether they are performed by the Goldmann perimeter technique or by use of a standardized automated perimetry technique.
4. Visual fields are not necessary for patients with an anophtholmic socket who is experiencing ptosis of difficulty with their prosthesis.
5. For a combination of any of the above procedures (blepharoptosis repair, blepharoplasty repair and brow ptosis repair): the medical necessity criteria for each procedure must be met and the additional criteria of the visual field testing demonstrates visual impairment that cannot be addressed by one procedure alone, must also be met.

D. Relief of eye symptoms associated with blepharospasm. Primary essential idiopathic blepharospasm is characterized by severe squinting, secondary to uncontrollable spasms of the periorbital muscles. Occasionally, it can be debilitating. If other treatments have failed or are contraindicated (i.e., an injection of Botulinum Toxin A,) an extended blepharoplasty with wide resection of the orbicularis oculi muscle complex may be necessary. (See Botulinum Toxin Type A and Type B, L34635)

“Cosmetic and Reconstructive Surgery” (L34698) for services performed on or after 10/31/19:

A. According to the American Society of Plastic and Reconstructive Surgeons, the specialty of plastic surgery includes reconstructive and cosmetic procedures:
1. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, involutional defects, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.
2. Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

Per the Medicare Benefit Policy Manual cosmetic surgery or expenses incurred in connection with such surgery, for the sole purpose of improving one’s appearance, is not covered.

B. Indications for specific surgical procedures:
1. Breast reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is covered.
2. Removal or revision of a breast implant is considered medically necessary when it is removed for one of the following reasons:

a. Mechanical complication of breast prosthesis; including rupture or failed implant, and/or implant extrusion.
b. Infection or inflammatory reaction due to a breast prosthesis; including infected breast implant, or rejection of breast implants.
c. Other complication of internal breast implant; including siliconoma, granuloma, interference with diagnosis of breast cancer, and/or painful capsular contracture with disfigurement.

3. Reduction Mammoplasty is the surgical reshaping of the breasts to reduce or lift enlarged or sagging breasts. Cosmetic surgery to reshape the breasts to improve appearance is not a Medicare benefit.

Macromastia (breast hypertrophy) is an increase in the volume and weight of breast tissue relative to the general body habitus. Breast hypertrophy may adversely affect other body systems: musculoskeletal, respiratory, and integumentary. Unilateral hypertrophy may result in symptoms following contralateral mastectomy.

Medical necessity for a reduction mammoplasty is limited to circumstances in which: There are signs and/or symptoms resulting from the enlarged breasts (macromastia) that have not responded adequately to non-surgical interventions, and to reduce the size of a normal breast to bring it into symmetry with a breast reconstructed after cancer surgery.

Non-surgical interventions preceding reduction mammoplasty should include as appropriate, but are not limited to, the following:

- Determining the macromastia is not due to an active endocrine or metabolic process.
- Determining the symptoms are refractory to appropriately fitted supporting garments, or following unilateral mastectomy, persistent with an appropriately fitted prosthesis or reconstruction therapy at the site of the absent breast.
- Determining that dermatologic signs and/or symptoms are refractory to, or recurrent following, a completed course of medical management.

A medically reasonable and necessary reduction mammoplasty could be indicated in the presence of significantly enlarged breasts and the presence of at least one of the following signs and/or symptoms:

a. Back, neck or shoulder pain from macromastia and unrelieved by 6 months of:
    1. Conservative analgesia,
    2. Supportive measures (garment, etc.),
    3. Physical Therapy, or
b. Significant arthritic changes in the cervical or upper thoracic spine, optimally managed with persistent symptoms and/or significant restriction of activity, or
c. Intertriginous maceration or infection of the inframammary skin refractory related to dermatologic measures.
d. Permanent shoulder grooving with skin irritation by supporting garment (bra strap).

The amount of breast tissue to be removed must be proportional to the body surface area (BSA) per the Schnur scale below. If only one breast meets the Schnur scale criteria; breast tissue may be removed from the other breast in order to achieve symmetry.

Schnur Scale:

Body Surface Area (m^2)	**Average grams of tissue per breast to be removed**
1.40-1.50	218-260
1.51–1.60	261-310
1.61-1.70	311-370
1.71-1.80	371-441
1.81-1.90	442-527
1.91-2.00	528-628
2.01-2.10	629-750
2.11-2.20	751-895
2.21-2.30	896-1068
2.31-2.40	1069-1275
2.41-2.50	1276-1522
2.51-2.60	1523-1806
2.61-2.70	1807-2154
2.71-2.80	2155-2568
2.81-2.90	2569-3061
2.91-3.00	3062-3650

4. Mastectomy for gynecomastia
   Gynecomastia is the excessive growth of the male mammary glands. These conditions can cause significant clinical manifestations when the excessive breast weight adversely affects the supporting structures of the shoulders, neck, and trunk. Payment may be made for this procedure if it is documented that the tissue is primarily breast tissue and not just adipose (fatty tissue).
5. Tattooing to correct color defects of the skin may be considered reconstructive when performed in connection with a payable post-mastectomy reconstruction, or for reconstruction following trauma or removal of cancer from an eyelid, eyebrow or lip(s).
6. Punch graft hair transplant may be considered reconstructive when it is performed for eyebrow(s) replacement following a burn injury or tumor removal.
7. Rhinoplasty that is performed to improve nasal respiratory function due to airway obstruction or stricture, repair deficits caused by trauma, revise structural deformities produced by trauma or nasal cutaneous disease, or replace nasal tissue lost after tumor ablative surgery is covered.
   a. Nasal fracture
   b. Benign or malignant neoplasms
   c. Nasal Obstruction
8. Chemical Peel
   Is covered for the treatment of Actinic Keratosis.
9. Dermabrasion, segmental, face is covered for the treatment of rhinophyma.
10. Dermal injections for facial LDS using dermal fillers approved by the FDA for this purpose, and then only in HIV-infected Medicare beneficiaries who manifest depression secondary to the physical stigma of HIV treatment will be covered. Effective for claims with dates of service on and after March 23, 2010.

See Pub. 100-03, *Medicare National Coverage Determinations* Chapter 1, Coverage Determinations Part 4, Section 250.5, Dermal Injection for the Treatment of Facial

Lipodystrophy Syndrome.
See Pub. 100-04, *Claims Processing Manual*, Chapter 32, Section 260, Dermal Injection for the Treatment of Facial Lipodystrophy Syndrome.

National Coverage Determination 250.5 Dermal Injections for the treatment of Facial Lipodystrophy Syndrome

C. The following procedures will be considered on an individual basis.
   1. Rhytidectomy is considered medically necessary to correct a functional impairment as a result of a disease state ie; facial paralysis. Often this procedure is performed in conjunction with other procedures to correct the impairment.
   2. Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty) will only be considered reasonable and medically necessary when these procedures are performed due to another surgery being done at the same time and would affect the healing of the surgical incision.

      This procedure may also be considered to be medically necessary for the patient that has had a significant weight-loss following the treatment of morbid obesity **and** there are medical complications such as candidiasis, intertrigo or tissue necrosis that is unresponsive to oral or topical medication.

These claims will be reviewed by the medical staff and considered on a case by case basis. Medical Records will be requested by the Contractor to determine medical necessity. See Documentation Requirements section of this LCD.

"Removal of Benign Skin Lesions" (L35498); Effective date 10/01/15; Revision date: 10/31/19

This policy addresses the Medicare coverage for the removal of benign skin lesions, such as seborrheic keratoses, sebaceous (epidermoid) cysts and skin tags. Benign skin lesions are common in the elderly and are frequently removed at the patient's request to improve appearance. Removal of certain benign skin lesions that does not pose a threat to health or function, are considered **COSMETIC** and as such are not covered by the Medicare program.

A. Medical Indications
   There may be instances in which the removal of non-malignant skin lesions is medically appropriate. Medicare will, therefore, consider their removal as medically necessary and not **COSMETIC**, if one or more of the following conditions are present and clearly documented in the medical record:
   1. The lesion has one or more of the following characteristics: bleeding, itching, pain; change in physical appearance (reddening or pigmentary change), recent enlargement, increase in number; or
   2. The lesion has physical evidence of inflammation, e.g., purulence, edema, erythema; or
   3. The lesion obstructs an orifice; or
   4. The lesion clinically restricts vision; or
   5. There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on the lesion appearance; or
   6. A prior biopsy suggests or is indicative of lesion malignancy; or
   7. The lesion is in an anatomical region subject to recurrent trauma, and there is documentation of such trauma.

8. Wart removals will be covered under the guidelines listed above. In addition, wart destruction will be covered when any one of the following clinical circumstances is present:
    a. Periocular warts associated with chronic recurrent conjunctivitis thought secondary to lesion virus shedding.
    b. Warts showing evidence of spread from one body area to another, particularly in immunosuppressed patients.
    c. Lesions are condyloma acuminata or molluscum contagiosum.
    d. Cervical dysplasia or pregnancy is associated with genital warts.

"Treatment of Varicose Veins of the Lower Extremities" (L34536); Effective Date: 10/01/15; Revision Date: 11/01/19

- The treatment of asymptomatic varicose veins, or symptomatic varicose veins without a 3-month trial of conservative measures, by any technique, will be considered COSMETIC and therefore not covered.
- The treatment of spider veins or superficial telangiectasis by any technique is also considered COSMETIC, and therefore not covered unless there is associated bleeding.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

- Abdominoplasty
- Blepharoplasty and Repair of Brow Ptosis
- Chemical Peels
- Reconstructive Breast Surgery/Management of Breast Implants
- Reduction Mammaplasty for Breast-Related Symptoms
- Refractive Keratoplasties and Implantation of Intrastromal Corneal Ring Segments
- Surgical Treatment for Male Gynecomastia

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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 11/30/20, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
4/24/02	4/24/02	4/24/02	Joint policy created
7/27/04	7/27/24	7/27/24	Routine maintenance
7/1/06	5/2/06	4/14/06	Routine maintenance
7/1/07	3/31/07	3/31/07	Routine maintenance
11/1/08	8/19/08	10/30/08	Routine maintenance
3/1/12	12/13/11	1/31/12	Routine maintenance, table of cosmetic vs reconstructive procedures added.
3/1/13	12/11/12	12/31/12	Routine maintenance; revised criteria Inclusion section in subsection "Excision of excessive skin" and "Rhinoplasty"; updated references and CMS information.
1/1/14	10/15/13	10/25/13	Added procedures testicular prostheses and cryotherapy; removed phrase "diagnostic option" from MPS; clarified definition of 'cosmetic' for excision of excessive skin; revised criteria regarding laser resurfacing of the skin, added active acne vulgaris; revised criteria for correction of telangiectasias or spider veins; revised criteria for reduction of labia majora and minora; revised dermabrasion and microdermabrasion criteria, added "Dermabrasion and microdermabrasion are not recommended for the treatment of active acne vulgaris" and "Reconstructive when used to treat actinic keratosis or other pre-cancerous skin lesions"; clarified MPS by adding additional indications for reconstructive surgery "congenital defects, developmental abnormalities, trauma, infection, involutional defects, tumors or disease"; updated rationale and

			references.
5/1/15	2/17/15	2/27/15	Routine maintenance Inclusions updated with ablative/non-ablative fractional and micro-fractional CO_2 laser resurfacing for burn scars
5/1/16	2/16/16	2/16/16	Routine maintenance
5/1/17	2/21/17	2/21/17	Routine maintenance
5/1/18	2/20/18	2/20/18	Routine maintenance
5/1/19	2/19/19		Routine maintenance
7/1/19	4/16/19		0479T and 0480T added as EST
5/1/20	2/18/20		• Routine maintenance • Voice lifting procedures added as cosmetic • Incorporated IMP "Treatment of Lower Extremity Lymphedema with Liposuction" – Cosmetic
5/1/21	2/16/21		• Routine maintenance

Next Review Date: 1st Qtr, 2022

Pre-Consolidation Medical Policy History

Original Policy Date	Comments
BCN: 10/4/94	Revised: 5/8/01
BCBSM: N/A	Revised: N/A

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: COSMETIC AND RECONSTRUCTIVE SURGERY

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered; criteria apply.
BCNA (Medicare Advantage)	Refer to the Medicare information under the Government Regulations section of this policy.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.