Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

***Current Policy Effective Date: 7/1/25**
(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 2 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; 1 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 an individual 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

In the absence of a *functional* deficit, reconstructive surgery may be used to restore a patients 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	• *Cosmetic*
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 *(see Excision of Excess skin inclusions below for mastopexy)*	• *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 *(see Excision of Excess skin inclusions below for mastopexy)*	• *Cosmetic* if done to improve appearance in the absence of functional deficits • *Reconstructive* if policy guidelines are met. See joint policy, "Breast Reduction 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: o 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 o 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*
Ear piercing	• *Cosmetic*
Electrolysis	• *Cosmetic* • *Reconstructive* if patient meets policy guidelines. Refer to Transgender Services policy for criteria

Excision of excessive skin of the thigh, leg, hip, buttock, arm, forearm, hand, mastopexy (breast lift with removal of excess skin), submental fat pad or other areas	• *Cosmetic* if the primary purpose is to change or improve appearance when there is no specific functional deficit (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* for both allografts (e.g., Renuva) and autografts
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).
Lipectomy (excisional surgical procedure that involves the removal of excess fat and skin from specific areas of the body)	• *Cosmetic*
Liposuction (suction assisted procedure which removes fat tissue through small incisions)	• *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.
Panniculectomy	• *Reconstructive* if patient meets policy guidelines. See "Related Policies."
Pectus excavatum - minimally invasive repair (e.g., Nuss procedure)	• *Cosmetic: C*riteria below are not met. • *Reconstructive:* Two or more of the following are met: o Medical history reveals the patient is symptomatic. Symptoms include shortness of breath with exercise, lack of endurance, and chest pain. o Physical exam reveals moderate to severe[a] pectus excavatum deformity which may be symmetric or asymmetric. o CT or MRI of the chest indicates severe[a] pectus deformity defined by a Haller index greater than 3.2 or correction index greater than 10%, cardiac and/or pulmonary compression or displacement. o Pulmonary function studies demonstrate a restrictive or obstructive pattern. o Cardiology evaluation reveals cardiac compression or displacement, rhythm disturbance, and/or mitral valve prolapse. o Psycho-social maladjustment[b]. *[a]Haller index score – Normal is 2 or less; Mild deformity is between 2 and 3.2; Moderate deformity is between 3.2 and 3.5; Severe deformity is greater than 3.5.* *[b]Two additional bullets must be applied with this criterion for surgery to be covered*
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).
Rhytidectomy (a surgical procedure that aims to improve the appearance of the face and neck by removing excess skin and tightening underlying tissues) Includes:	• *Cosmetic*

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.
Vaginal rejuvenation/vulvovaginal atrophy	• *Cosmetic* ○ Includes use of energy-based devices (e.g., laser, radiofrequency thermal treatment)
Varicose veins	• *Cosmetic* • *Reconstructive* if individuals met policy guidelines. Refer to Echoscleortherapy for the Treatment of Varicose Veins and/or Endovenous Ablation for the Treatment of Varicose Veins (e.g., ClariVein®, VenaSeal™, Closure System)
Vocal Cord Medialization	• *Cosmetic* for any indication not listed below. • *Reconstructive* if the surgical or injection procedure is used to move a paralyzed or non-functioning vocal cord closer to the functioning one to restore the ability to speak, swallow, or to protect the airway.
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: 1/1/1997

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 non-cosmetic 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); Original effective date: 10/1/15; Revision effective date: 12/28/23

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 (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. 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.

C. 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" (L39051) for services performed on or after 10/13/24:

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 and may be covered as surgery is considered reconstructive in nature.
   2. Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Please refer to CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16: Section 120 for detailed information.
      - Corrective facial surgery will be considered cosmetic rather than reconstructive when there is no functional impairment present. However, some congenital, acquired, traumatic or developmental anomalies may not result in functional impairment, but are so severely disfiguring (e.g., but not limited to severe burns or repair of the face following a serious automobile accident) as to merit consideration for corrective surgery.
      - Treatment of complications arising from **cosmetic** surgery will be considered reasonable and necessary as long as infection, hemorrhage or other serious documented medical complication occurs, and the beneficiary has been officially discharged from the facility.

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, whether placed for reconstructive or cosmetic reason, 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. Breast reduction 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 breast reduction 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
   - To improve or correct asymmetry following cancer surgery on one breast.
     Note: either the involved breast or contralateral breast may be treated to achieve symmetry.
     Note: For coverage indications for contralateral reconstruction of an unaffected breast following a medically necessary mastectomy, refer to the CMS Internet-Only Manual, Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Part 2, §140.2.

   Non-surgical interventions preceding breast reduction 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 breast reduction could be indicated in the presence of significantly enlarged breasts and the presence of at least one of the following signs and/or symptoms:
   - Back, neck or shoulder pain from macromastia and unrelieved by 6 months of:
     - Conservative analgesia,
     - Supportive measures (garment, etc.),
     - Physical Therapy, or
   - Significant arthritic changes in the cervical or upper thoracic spine, optimally managed with persistent symptoms and/or significant restriction of activity, or
   - Intertriginous maceration or infection of the inframammary skin refractory related to dermatologic measures.
   - 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 Schnur18 scale below. If the individual's body surface area and weight of breast tissue removed fall above the 22nd percentile, then the surgery is considered medically reasonable and necessary with the appropriate criteria. 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.

   Mastectomy with nipple preservation or reduction mammoplasty is considered reconstructive and a covered service for males with gynecomastia Grade III and IV or abnormal breast development with redundancy.
   - Persists more than 3 to 4 months after the pathological causes are ruled out (e.g., not limited to testosterone deficiency, testicular tumor, liver disease, or drug induced).
   - Persists after 3 to 4 months of unsuccessful medical treatment for pathological gynecomastia.
   - Pain or tenderness directly related to the breast tissue which has a clinically significant impact upon activities of daily living.
   - Clinical symptoms refractory to a trial of analgesics or anti-inflammatory agents.
   - For significant clinical manifestations when the excessive breast weight adversely affects the supporting structures of the shoulders, neck and trunk.

   American Society of Plastic Surgeons' gynecomastia scale:
   - Grade I: Small breast enlargement with localized button of tissue that is concentrated around the areola.
   - Grade II: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest.
   - Grade III: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest with skin redundancy present.

- Grade IV: Marked breast enlargement with skin redundancy and feminization of the breast

5. Gigantomastia of Pregnancy
   Medicare considers subtotal mastectomy or reduction mammoplasty for the unusual condition of Gigantomastia of Pregnancy accompanied by any of the following complications (and delivery is not imminent) medically reasonable and necessary when signs or symptoms are refractory to medical treatment or physical interventions have not adequately alleviated symptoms such as:
   - Massive infection
   - Significant hemorrhage
   - Tissue necrosis with slough
   - Ulceration of breast tissue
   - Intertriginous maceration or infection of the inframammary skin refractory to dermatologic measures.
6. 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).
7. Punch graft hair transplant may be considered reconstructive when it is performed for eyebrow(s) replacement following a burn injury or tumor removal.
8. Nasal surgery, including rhinoplasty, may be reconstructive or cosmetic in nature. Current CPT Codes do not allow distinction of cosmetic or reconstructive procedures by specific codes; therefore, categorization of each procedure is to be distinguished by the presence or absence of specific signs or symptoms.
   - Nasal surgery, including rhinoplasty, may be reconstructive or cosmetic in nature. Current CPT Codes do not allow distinction of cosmetic or reconstructive procedures by specific codes; therefore, categorization of each procedure is to be distinguished by the presence or absence of specific signs or symptoms.
   - Rhinoplasty is a procedure that changes the shape or appearance of the nose while improving or preserving the nasal airway. The primary purpose for Rhinoplasty can be functional, aesthetic, or both and may include other procedures on the paranasal sinuses, septum, or turbinates.
   - Septoplasty is a procedure used to correct deformities of the nasal septum which can often cause issues with airflow and difficulty breathing.
9. Rhinoplasty is considered medically reasonable and necessary when the procedure is performed for correction and repair of any of the following indications:
   - Secondary to trauma, disease, congenital defect with nasal airway obstruction that has not resolved after previous septoplasty/turbinectomy or would not be expected to resolve with septoplasty/turbinectomy alone.
   - chronic, non-septal, nasal obstruction due to vestibular stenosis (i.e., collapsed internal valves).
   - nasal deformity secondary to a cleft lip/palate or other congenital craniofacial deformity causing a functional impairment. (e.g., cleft lip nasal deformities, choanal atresia, oronasal or oromaxillary fistula)

   Septoplasty is considered medically necessary when performed for any of the following indications:
   - septal deviation/deformity causing nasal airway obstruction that has proved unresponsive to a trial of conservative medical management lasting at least 6

weeks (e.g., topical nasal corticosteroids, decongestants, antibiotic, allergy evaluation and therapy, etc.).
- recurrent sinusitis (4 or more episodes in a year) secondary to a deviated septum that does not resolve after appropriate medical and antibiotic therapy.,
- recurrent epistaxis (4 or more significant episodes) related to a septal deformity.
- asymptomatic septal deformity that prevents access to other trans nasal areas when such access is required to perform medically necessary procedures (e.g., ethmoidectomy).
- performed in association with cleft lip or cleft palate repair.
- obstructed nasal breathing due to septal deformity or deviation that has proved unresponsive to medical management and is interfering with the effective use of medically necessary Continuous Positive Airway Pressure (CPAP) for the treatment of an obstructive sleep disorder.

10. Chemical Peel
    - Is covered for the treatment of Actinic Keratosis.
11. Dermabrasion is considered medical reasonable and necessary when correcting defects resulting from traumatic injury, surgery or disease.
    - Dermabrasion, segmental, face in conjunction with antimicrobial therapy is covered for the treatment of rhinophyma. Rhinophyma is characterized by skin thickening, which can cause an enlargement of the nose due to excess tissue and overgrowth of sebaceous glands.7 Rhinophyma in its most severe cases can affect breathing and even vision.
12. Dermal injections for facial lipodystrophy syndrome (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.
13. Abdominal Lipectomy/Panniculectomy
    - Panniculectomy will be considered medically necessary when the pannus or panniculus hangs below the level of the pubis, and the medical records document that the panniculus causes chronic intertrigo (dermatitis occurring on opposed surfaces of the skin, skin irritation, infection or chafing that consistently recurs or remains refractory to appropriate medical therapy (e.g., topical antifungals, corticosteroids, antibiotics) over a period of 3 months.
    - When surgery is performed to alleviate such complicating factors as inability to walk normally due to pannus size, chronic pain, ulceration created by the abdominal skin fold, or intertrigal dermatitis, such surgery is considered reconstructive. Preoperative photographs may be required to support justification and should be supplied upon request.[12]
    - This procedure may also be medically necessary for the patient that has had a significant weight-loss following the treatment of morbid obesity, in addition to meeting the criteria noted above, there should be evidence that the individual has maintained a stable weight for at least 6 months. If the weight loss is the result of bariatric surgery, abdominoplasty/panniculectomy should not be performed until at least 18 months after bariatric surgery and only when weight has been stable for

at least the most recent 6 months and infection and inflammation has continued for the most recent 3 months.

C. The following procedures are non-covered for the following indications.

Limitations

1. Cosmetic surgery performed to treat psychiatric or emotional problems is not covered.
2. If a non-covered cosmetic surgery is performed in the same operative period as a covered surgical procedure, benefits will be provided for the covered surgical procedure only.
3. Dermabrasion
   - Post-acne scarring
   - Rosacea other than rhinophyma
   - All other indications not identified as covered in the section above
4. Abdominal Lipectomy/Panniculectomy
   - Repairing abdominal wall laxity, or diastasis recti
   - Redundancies resulting from weight loss or weight loss surgery when that tissue is without evidence of chronic infection or inflammation that is refractory to conservative treatment as outlines in the indications listed above.
   - Solely to improve appearance
   - All other indications unless covered in the section above

   Note: Abdominal Lipectomy/Panniculectomy is considered experimental and investigational for minimizing the risk of hernia formation or recurrence. There is no evidence that pannus contributes to hernia formation. The primary cause of hernia formation is an abdominal wall defect or weakness, not a pulling effect from a large or redundant pannus.
5. Liposuction used for body contouring, weight reduction or the harvest of fat tissue for transfer to another body region for alteration of appearance or self-image or physical appearance is considered **COSMETIC AND** not covered as medically necessary.
6. Reconstructive Breast Surgery: Removal of Breast Implants for re-implantation of an implant inserted for cosmetic purposes only and not for history of mastectomy for treatment of breast cancer, lumpectomy, or treatment of contralateral breast to bring it into symmetry with a reconstructed breast following cancer surgery is not a covered Medicare benefit.
7. Reduction Mammaplasty
   - Surgery performed primarily to reshape the breasts to improve appearance or self-image.
   - Mammapexy unrelated to breast reconstruction following a medically necessary mastectomy.
8. Mastectomy for gynecomastia
   - Breast reduction or surgical mastectomy for gynecomastia, either unilateral or bilateral, as the first line treatment.
   - When performed solely to improve appearance of the male breast or to alter contours of the chest wall.
9. Gigantomastia of Pregnancy
   - Surgery to reshape the breasts to improve appearance or self-image.
   - All other indications not identified as covered in the section above.
10. Corrective facial surgery will be considered cosmetic in nature or not medically necessary:
    - Solely for the purpose of changing appearance or improving self-image in the absence of any signs or symptoms of functional abnormalities.

- As a primary treatment for an obstructive sleep disorder when the above criteria for approval have not been met.

11. Thyroid chrondoplasty to alter the appearance of the thyroid cartilage which is without functional defect is considered cosmetic.
12. Rhinoplasty is not covered when performed for either of the following indications because it is considered cosmetic in nature or not medically necessary:
    - Solely for the purpose of changing appearance or improving self-image in the absence of any signs or symptoms of functional abnormalities.
    - As a primary treatment for an obstructive sleep disorder when the above criteria for approval have not been met.
13. Rhytidectomy is generally considered a cosmetic procedure. It may be considered medically necessary upon review to correct a functional impairment as a result of a disease state i.e.; facial paralysis. Often this procedure is performed in conjunction with other procedures to correct the impairment.

"Removal of Benign Skin Lesions" (L35498); Effective date 10/01/15; Revision date: 10/26/23

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: 8/31/23

A. Indications for surgical treatment and sclerotherapy:
   1. A 3-month trial of conservative therapy such as exercise, periodic leg elevation, weight loss, compressive therapy, and avoidance of prolonged immobility where appropriate, has failed, AND
   2. The patient is symptomatic and has 1, or more, of the following:
      a. Pain, aching, cramping, burning, itching and/or swelling during activity or after prolonged standing severe enough to impair mobility
      b. Recurrent episodes of superficial phlebitis
      c. Non-healing skin ulceration
      d. Bleeding from a varicosity
      e. Stasis dermatitis
      f. Refractory dependent edema
   3. The treatment of spider veins/telangiectasis will be considered medically necessary only if there is associated hemorrhage.

B. Indications for ERFA or laser ablation:

In addition to the above (see A), the patient's anatomy and clinical condition are amenable to the proposed treatment including ALL of the following:
   1. Absence of aneurysm in the target segment.
   2. Maximum vein diameter of 20 mm for ERFA or 30 mm for laser ablation.
   3. Absence of thrombosis or vein tortuosity, which would impair catheter advancement.
   4. The absence of significant peripheral arterial diseases.

C. Limitations for ERFA and laser ablation:
   1. ERFA and laser ablation are covered only for the treatment of symptomatic varicosities of the lesser or greater saphenous veins and their tributaries which have failed 3 months of conservative therapy.
   2. Intra-operative ultrasound guidance is not separately payable with ERFA, laser ablation.
   3. 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.**
   4. The treatment of spider veins or superficial telangiectasis by any technique is also **considered cosmetic, and therefore not covered** unless there is associated bleeding.
   5. Coverage is only for devices specifically FDA-approved for these procedures.
   6. One pre-operative Doppler ultrasound study or duplex scan will be covered.
   7. Post –procedure Doppler ultrasound studies will be allowed if medically necessary.(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

- Blepharoplasty and Repair of Brow Ptosis
- Breast Reduction for Breast-Related Symptoms

- Chemical Peels
- Composite Tissue Allotransplantation
- Gender Affirming Services
- Lipedema – Surgical Treatments
- Panniculectomy
- Reconstructive Breast Surgery and Management of Breast Implants
- Refractive Keratoplasties, Phototherapeutic Keratectomy and Implantation of Intrastromal Corneal Ring Segments
- Surgical Treatment for Male Gynecomastia
- Treatment of Varicose Veins/Venous Insufficiency

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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 12/2/24, 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
5/1/22	2/18/22		• Routine maintenance • IMPs incorporated ○ Reconstructive repair or Pectus Excavatum; RF thermal treatment of vulvovaginal atrophy; and Laser vaginal rejuvenation • Updated LCD • Varicose veins added to criteria table
5/1/23	2/21/23		• Routine maintenance • Updated LCD • Policy replaced IMP for Renuva • Vendor managed: N/A
5/1/24	2/20/24		• Routine maintenance (slp) • Vendor managed: N/A
5/1/25	2/18/25		• Routine maintenance (slp) • Vendor managed: N/A • Vocal cord medialization added
7/1/25	4/15/25		• Off-cycle review to adjust criteria table

			• Added as EI: ○ Rhytidectomy and ear piercing • Split into separate rows for clarity: ○ Liposuction and lipectomy ○ Abdominoplasty (15847; EI) and panniculectomy

Next Review Date: 1st Qtr, 2026

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.