

Corporate Medical Policy

Cosmetic and Reconstructive Surgery

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Origination: 8/1979
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Description of Procedure or Service

Cosmetic procedures are those services intended to improve appearance and not primarily to restore bodily function or to correct significant deformity resulting from accidental injury, trauma, or previous therapeutic process.

Reconstructive procedures are performed on structures of the body for the purpose of improving/restoring bodily function or correcting significant deformity resulting from accidental injury, trauma, or previous therapeutic process.

*****Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.**

Policy

BCBSNC will not provide coverage for cosmetic procedures as defined above.

BCBSNC will provide coverage for Reconstructive Procedures when they are determined to be medically necessary because the medical criteria and guidelines shown below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

Some certificates limit coverage of reconstructive surgery following trauma or injuries occurring while a member.

When Cosmetic and Reconstructive Surgery is covered

- A. Cosmetic surgery: not applicable
- B. Reconstructive surgery is covered for **either of the following** indications:
 - 1. The procedure is intended primarily to improve/restore bodily function or to correct significant deformity resulting from accidental injury, trauma, or previous therapeutic process **OR**

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2. The procedure is intended to correct congenital or developmental anomalies that have resulted in significant functional impairment.

When Cosmetic and Reconstructive Surgery is not covered

- A. Cosmetic surgery or procedures are not covered at any time. Psychiatric and/or emotional distress are not considered as medically necessary indications for cosmetic procedures.
- B. Reconstructive surgery or procedures are not covered:
 1. When they do not correct a congenital or developmental anomaly that has resulted in significant functional impairment.
 2. In the absence of documentation that the procedure was performed primarily to restore/improve bodily function or to correct deformity resulting from accidental injury, trauma, or previous therapeutic process.

*****NOTE: BCBSNC does not cover investigational, cosmetic or not medically necessary services and will not reimburse for any services, procedures, drugs or supplies associated with those investigational, cosmetic or not medically necessary services.**

Examples of Cosmetic and Reconstructive Surgery

Cosmetic Procedures	Reconstructive Procedures
**Hairplasty for any form of alopecia	When meets the definition of reconstruction.
Excision/correction of glabellar frown lines	Not reconstructive
*Blepharoplasty of upper lids for blepharochalasis (skin excess) without documentation of upper/ outer visual fields impairment <u>Refer to Medical Policy entitled Reconstructive Eyelid Surgery and Brow Lift for policy guidelines.</u>	*Blepharoplasty of upper lids for documented peripheral vision impairment. Prior approval may be required.
*Blepharoplasty of lower lids for skin excess <u>Refer to Medical Policy entitled Reconstructive Eyelid Surgery and Brow Lift for policy guidelines.</u>	*Blepharoplasty of lower lids for Corneal and/or conjunctival injury or disease due to ectropion, entropion or trichiasis
*Otoplasty for large or protruding ears <u>Refer to Medical Policy entitled Otoplasty for policy guidelines.</u>	*Otoplasty for absent or deformed ears resulting from congenital absence, trauma or accidental injury
Rhinoplasty for external nasal deformity <u>not due</u> * to trauma or accidental injury <u>Refer to Medical Policy entitled Rhinoplasty for policy guidelines.</u>	Rhinoplasty for external nasal deformity due to trauma* or accidental injury

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Rhytidectomy of face for aging skin	Rhytidectomy for the treatment of burns
Epidermal chemical peels used to treat photoaged skin, wrinkles, or acne scarring <u>Refer to Medical Policy entitled Non-Pharmacologic Treatment of Rosacea</u>	Epidermal chemical peels used to treat patients with active acne that have failed a trial of topical and/or oral antibiotic acne therapy
Dermal chemical peels used as treatment of end-stage acne scarring	Dermal chemical peels used to treat patients with numerous (>10) actinic keratosis or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical
Laser resurfacing for wrinkling, aging skin, acne vulgaris or telangiectasias resulting from rosacea <u>Refer to Medical Policy entitled Non-Pharmacologic Treatment of Rosacea</u>	Laser resurfacing used to treat patients with numerous (>10) actinic keratosis or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical
Dermal fillers and volume producing agents such as but not limited to Poly-L-Lactic (Sculptra) and Radiesse	Dermal fillers and volume producing agents such as but not limited to Poly-L-Lactic (Sculptra) and Radiesse are not reconstructive as they are specifically used to improve appearance.
Dermabrasion for wrinkling or pigmentation or severe acne scarring	Not reconstructive
Electrolysis for hirsutism	Not reconstructive
Chin implant for deformity not the result of accidental injury or trauma	Chin implant for deformities of the maxilla or mandible resulting from trauma* or accidental injury
Neck tuck or lift	Not reconstructive
Pectus excavatum repair when asymptomatic	Pectus excavatum repair when documented functional impairment exists. <u>Refer to Medical policy, Surgical Treatment of Chest Wall Deformities (Congenital or Acquired).</u>
Insertion or injection of prosthetic material to replace absent adipose tissue <u>Refer to Medical Policy entitled Collagen Implantation or Prosthetic Appliances for policy guidelines</u>	Insertion or injection of prosthetic material for significant deformity from accidental injury or trauma
Augmentation of small but otherwise normal breasts <u>Refer to Medical Policy entitled Breast Surgeries for policy guidelines</u>	Not reconstructive
*Removal of breast tissue in the male for gynecomastia (the presence of glandular breast tissue in males) resulting from obesity, adolescence, or drug treatment which can be discontinued <u>Refer to Medical Policy entitled Breast Surgeries for policy guidelines</u>	*Removal of breast tissue in the male for gynecomastia which is not the result of obesity, adolescence, or reversible effects of drug treatment which cannot be discontinued**
Repositioning of the breast	*Post mastectomy reconstruction of the remaining breast, including reconstruction of

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<p><u>Refer to Medical Policy entitled Breast Surgeries for policy guidelines</u></p>	<p>the nipple and areolar complex. Reconstruction of the contralateral (non-diseased) breast may be necessary to achieve symmetry between the two breasts and would be eligible for coverage.</p>
<p>Telangiectasis or spider veins</p> <p><u>Refer to Medical Policy entitled Varicose Veins, Treatment for, for policy guidelines</u></p>	<p>Covered when medical necessity criteria are met.</p> <p><u>Refer to Medical Policy entitled Varicose Veins, Treatment for, for policy guidelines</u></p>
<p>Laser treatment of port wine stains</p>	<p>Laser treatment of port wine stains in the presence of functional impairment related to the port wine stain may be considered medically necessary.</p> <p><u>Refer to Medical Policy entitled, Laser Treatment of Port Wine Stain for policy guidelines.</u></p>
<p>Panniculectomy (tummy tuck) is generally cosmetic</p>	<p>A panniculectomy may be considered reconstructive when all of the following criteria are met: ***Note: Photographs and documentation may be required.</p> <ul style="list-style-type: none"> • The pannus hangs at or below the level of the pubic symphysis; <u>AND</u> • There has been a significant weight loss (>100lbs)*; <u>AND</u> • If the weight loss was accomplished without bariatric surgery, the member must have maintained a stable weight for a minimum of 6 months and have a BMI of <35*, or • If the weight loss is a result of bariatric surgery, a panniculectomy should not be performed until at least 18 months after surgery and only after weight has been stable for the most recent 6 months, and the member has a BMI of <35*, <u>AND</u> • The pannus causes bacterial cellulitis that: <ul style="list-style-type: none"> ○ Failed to respond or recurred after at least two courses of antibiotic treatment (oral or parenteral); <u>AND</u> ○ Is unresponsive to conservative treatment including adequate hygiene and topical anti-infective medications; <u>AND</u> ○ Has been present for over a 6 month period resulting in fibrosis and thickening of the pannus with discoloration and/or lymphedema or peau d'orange effect (pitting or prominence of pores due to fibrosis and swelling) of the overlying skin.

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	*The majority of requests for coverage for panniculectomy are for patients who have sustained significant weight loss, or who remain morbidly obese. Because surgical outcomes are superior when performed in patients who have achieved stable weight loss, BCBSNC requires that stable weight loss with BMI less than 35 be obtained prior to authorization of coverage for panniculectomy surgery, except in rare, unusual cases.
Diastasis recti repair in the absence of a true midline hernia	Not reconstructive
Excision/treatment of decorative tattoos	Excision/treatment of tattoos of traumatic or therapeutic origins
Repair/revision of asymptomatic scars	Repair/revision of significantly symptomatic scars resulting from covered surgery or therapeutic process
*Psoralens ultraviolet A (PUVA), UVB light box , or any other light therapy for the treatment of vitiligo	Not reconstructive
Lipectomy or liposuction	Not reconstructive

* Some certificates limit coverage of reconstructive surgery following trauma or injury occurring while a member.

**Hair serves little or no functional purpose, thus restoration of hair loss is generally considered cosmetic. Psychiatric and/or emotional distress are not considered medically necessary indications for cosmetic procedures. Benefits are available for treatment of the underlying medical disease causing hair loss.

Policy Guidelines

- Any strabismus treatment in individuals 18 years of age or older is covered if the reconstructive criteria are met.
- Occasionally, there may be congenital anomalies which do not result in functional impairment but which are so severely disfiguring as to merit consideration for corrective surgery. Examples are the cranio-facial anomalies associated with Crouzon's Syndrome and Treacher-Collins Syndrome.
- Poly-L-lactic acid injection (Sculptra) used for HIV lipoatrophy is considered cosmetic because the sole purpose is to improve appearance, and it does not restore physiological function.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: Refer to the individual codes for each specific procedure.

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If documentation is requested, it should include the following:

1. Medical records indicating that the procedure will be or was performed to restore/improve bodily function or to correct deformity resulting from accidental injury, trauma, or previous therapeutic process. In the absence of this documentation, the surgery or procedure must be considered cosmetic
2. Photographs
3. Copies of consultations
4. Operative reports
5. Any other pertinent information

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

BCBSA Medical Policy Reference Manual

Certificate Provisions

North Carolina Senate Bill 714, Provision of Coverage for Reconstructive Breast Surgery Resulting from Mastectomy, July 10, 1997

Medical Policy Advisory Group - 12/2/99

Specialty Matched Consultant Advisory Panel - 7/2000

Medical Policy Advisory Group - 9/14/2000

Specialty Matched Consultant Advisory Panel - 10/2000

Medical Policy Advisory Group - 12/2000

Specialty Matched Consultant Advisory Panel - 9/2002

BCBSA Medical Policy Reference Manual, 8.01.16, 7/12/02

BCBSA Medical Policy Reference Manual, 10.01.09, 7/12/02

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.01.16, 10/9/03

BCBSA Medical Policy Reference Manual [Electronic Version]. 10.01.09, 10/9/03

van Zuuren, EJ, Graber, MA, Hollis, S, Chaudhry, M, Gupta, AK. (2004) Interventions for rosacea. The Cochrane Library, Issue 2. Retrieved on 5/11/04 from <http://212.49.218.203/newgenMB/ASP/Document.asp?docNo=977>.

Specialty Matched Consultant Advisory Panel - 7/2004

Specialty Matched Consultant Advisory Panel - 6/2006

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Medical Director Review 7/2007

Specialty Matched Consultant Advisory Panel - 5/29/08

Senior Medical Director Review - 9/2009

Specialty Matched Consultant Review - 7/2009

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.40, 6/10/10

Specialty Matched Consultant Advisory Panel review 9/2010

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.01.16, 7/14/11

Specialty Matched Consultant Advisory Panel review 9/2011

Policy Implementation/Update Information

8/79 Original policy

6/83 Reaffirmed

3/85 Reaffirmed

4/86 Reaffirmed with revisions

9/88 Reaffirmed with revisions

3/89 Reaffirmed with revisions

Local Review Dates

1/93 Reviewed: PCP Physician Advisory Group

11/93 Reviewed: PCP Physician Advisory Group

11/95 Reviewed: PCP Physician Advisory Group

2/97 Revised: Hairplasty may be reconstructive if for permanent alopecia. References to local policies for blepharoplasty, otoplasty, removal of breast tissue for male gynecomastia and PUVA

8/97 Revised: Added statement under Policy section regarding Post-mastectomy reconstruction, "Reconstruction of the contralateral (non-diseased) breast may be necessary to achieve symmetry between the two breasts and would be eligible for coverage" based on NC Senate Bill 714.

12/97 Revised: Notation regarding Medical Policy for Reconstructive Breast Surgery Post Mastectomy, (L)19324 added.

2/98 Revised: Notation added regarding Medical Policy for Rhinoplasty, (L)30420.SUR

7/99 Reformatted, Medical Term Definitions added.

12/99 Reaffirmed, Medical Policy Advisory Group

7/00 Specialty Matched Consultant Advisory Panel. No changes to criteria.

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9/00 Medical Policy Advisory Group review. Approve. No change in criteria. Typographic errors corrected.

12/00 Specialty Matched Consultant Advisory Group review. Examples of Cosmetic and Reconstructive procedures table reworked for clarity. Added telangiectasis, spider veins, congenital vascular malformations or Port Wine Stains to table. Medical Policy Advisory Group review. No change in criteria. Approve.

1/01 Added reference to Cosmetic and Reconstructive Procedures table to refer reader to Venous Insufficiency policy and Laser Treatment of Congenital Vascular Malformations for additional information. No change in criteria.

11/01 Coding format change.

4/02 Policy reformatted for clarity. Laser resurfacing added to Examples of Cosmetic and Reconstructive Procedures table. No change to Billing/Coding Section.

10/02 Specialty Matched Consultant Advisory Panel review. Added "or when future cardiovascular compromise is anticipated" to Reconstructive Procedures column for Pectus Excavatum. Added additional information concerning dermal and epidermal chemical peels, and panniculectomy. Removed reference to policy on Laser Treatment of Congenital Vascular Malformations.

5/13/04 Benefits Application and Billing/Coding sections updated for consistency. Statement added in grid under Cosmetic Procedures indicating that laser resurfacing for telangectasias resulting from rosacea is cosmetic. Notification given 5/13/04. Effective date 7/15/04.

8/12/04 Specialty Matched Consultant Advisory Panel review 7/14/2004. No changes to criteria. Added "or" under section When Cosmetic and Reconstructive surgery is covered at the end of B. 1. for clarification. Removed product names from Reconstructive Procedures table, Blepharoplasty. Now states "Prior approval may be required." References added.

7/24/06 Specialty Matched Consultant Advisory Panel review 6/20/2006. Added "Laser resurfacing used to treat patients with numerous (>10) actinic keratosis or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical." under "Reconstructive" indications. Added additional criteria to the reconstructive indication for panniculectomy to indicate; "A panniculectomy may be considered reconstructive when the pannus hangs at or below the level of the pubic symphysis and causes recurrent and significant bacterial cellulitis, that requires at least 2 treatments with an oral antibiotic and is unresponsive to conservative treatment including adequate hygiene and topical anti-infective medications over a 6 month period resulting in fibrosis and thickening of the pannus with discoloration and/or lymphedema or peau d'orange effect (pitting or prominence or pore due to fibrosis and swelling) of the overlying skin. If there has been a significant weight loss (>100lbs) the member must have maintained a stable weight for a minimum of 6 months. If the weight loss is a result of bariatric surgery a panniculectomy should not be performed until at least 18 months after surgery and only after weight has been stable for the most recent 6 months. Panniculectomy may be medically necessary when considered a critical part of a surgical repair of a clinically significant (>5cm) ventral or umbilical hernia . Photographs and documentation may be required." Updated names of specific referenced Medical Policies as appropriate. Added "liposuction, tummy tuck, lift" to "Key Words" section.

8/28/06 Revised the section under "Examples of Cosmetic and Reconstructive Procedures" regarding "panniculectomy" for clarification.

8/13/07 Updated references in policy to "disease" and replaced with the wording "accidental injury" for consistency with the benefit language definition of cosmetic. Added new information to "Examples of Cosmetic and Reconstructive Procedures" indicating "Dermal fillers and volume

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producing agents such as but not limited to Poly-L-Lactic (Sculptra) and Radiesse " under "Cosmetic" and "Dermal fillers and volume producing agents such as but not limited to Poly-L-Lactic (Sculptra) and Radiesse are not reconconstructive as they are specifically used to improve appearance." Added "severe acne scarring" to "Dermabrasion" as Cosmetic and "Not reconstructive". Added reference to the Medical Policy entitled "Collagen Implantation" in relation to "Insertion or injection of prosthetic material to replace absent adipose tissue." Added "UVB light box, and any other light therapy" to "Psoralent ultraviolet A (PUVA) for the treatment of vitiligo". Removed reference to the medical policy entitled PUVA (Psoralens with Ultraviolet A) Therapy. Under "Policy Guidelines" added the following statement; "Poly-L-lactic acid injection (Sculptra) used for HIV lipoatrophy is considered cosmetic because the sole purpose is to improve appearance and it does not restore physiological function." "Key Words" updated.

5/19/08 Under "Examples of Cosmetic and Reconstructive Surgery", revised statement "Telangiectasis or spider veins. Refer to Medical Policies entitled Varicose Vein Excision and Ligation, Endoluminal Radiofrequency or Laser Ablation of Varicose Veins, and Sclerotherapy as a Treatment of Varicose Veins for policy guidelines." to indicate the new combined policy entitled "Varicose Veins, Treatment for".

7/28/08 Specialty Matched Consultant Advisory Panel review 6/23/08. Added comment related to "hairplasty" under the "Reconstructive Procedures" section that indicates; "When meets the definition of reconstruction". Added "Refer to Medical Policy entitle Non-Pharmacologic Treatment of Rosacea, MED1307" in regards to "Epidermal chemical peels". Added "acne vulgaris" to the "Cosmetic Procedures" section regarding "Laser resurfacing". Reworded "A.2." in regards to reconstructive panniculectomy from; "causes recurrent and significant bacterial cellulitis, that has failed at least 2 treatments with an oral antibiotic." to "causes bacterial cellulitis that has failed to respond or recurred after at least two courses of antibiotic treatment." References added.

5/18/09 Added reference to " policy number SUR6684, Surgical Treatment of Chest Wall Deformities (Congenital or Acquired). " to "Pectus Excavatum" section in table.

9/28/09 Added ""***NOTE: BCBSNC does not cover investigational, cosmetic or not medically necessary services and will not reimburse for any services, procedures, drugs or supplies associated with those investigational, cosmetic or not medically necessary services." to the "When Not Covered" section for clarification. Updated the definition of "congenital" from "existing at, and usually before, birth; referring to conditions that are present at birth, regardless of their causation." to "existing at, and usually before, birth; referring to conditions that are apparent at birth, regardless of their causation." to be consistent with the member benefit booklet language. Reviewed with Senior Medical Director 9/2/09. (btw)

9/28/09 Reformatted information related to medical necessity for panniculectomy and added a requirement of "a BMI of <35". Also added informational note indicating; "The majority of requests for coverage for panniculectomy are for patients who have sustained significant weight loss, or who remain morbidly obese. Because surgical outcomes are superior when performed in patients who have achieved stable weight loss, BCBSNC requires that stable weight loss with BMI less than 35 be obtained prior to authorization of coverage for panniculectomy surgery, except in rare, unusual cases." Reviewed with Senior Medical Director 9/2/09. Notice given 9/28/09. Policy effective 1/5/10. (btw)

6/22/10 Policy Number(s) removed (amw)

9/14/10 Revised comments regarding Telangiectasis or spider veins under the Reconstructive Procedures that states, "Laser treatment of port wine stains in the presence of functional impairment related to the port wine stain may be considered medically necessary. Refer to Medical Policy entitled, Laser Treatment of Port Wine Stain for policy guidelines." Reference added. (mco)

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10/26/10 Specialty Matched Consultant Advisory Panel review 9/2010. Replaced “vaccination” with “asymptomatic” under “Repair/revision of scars” in Cosmetic Examples table. References updated. Reformatted the Billing/Coding section. (mco)

10/25/11 Removed ear piercing from section of policy titled, “Examples of Cosmetic and Reconstructive Surgery.” Under Reconstructive section for Otoplasty, added “congenital absence.” The following information was removed from the section titled, “Telangiectasis or spider veins” and is now a distinct category: “Laser treatment of port wine stains in the presence of functional impairment related to the port wine stain may be considered medically necessary. Refer to Medical Policy entitled, Laser Treatment of Port Wine Stain for policy guidelines.” Removed “dry eye” from the Reconstructive section of lower lid blepharoplasty and added the following conditions: “disease due to ectropion, entropion or trichiasis.” Specialty Matched Consultant Advisory Panel review 9/2011. References updated. (mco)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.