



Effective: 10/21/2022
Last Approved: 9/13/2022
Next Review: 10/31/2023
Lines Of Business: *All Lines of Business*

Cosmetic Procedures

PURPOSE:

This policy discusses procedures and services that are generally considered cosmetic in nature.

DEFINITIONS:

Cosmetic Surgery: Procedures or services that change or improve appearance without significantly improving physiological function.

Plastic Surgery: A surgical procedure dedicated to reconstruction of facial and body defects due to birth disorders, trauma, burns, and disease. Plastic surgery is intended to correct dysfunctional areas of the body and is reconstructive in nature.

PROCEDURE:

1. The following procedures are considered cosmetic nature, and therefore not medically necessary (not intended to be an all-inclusive list):
 - Abdominoplasty
 - Blepharoplasty
 - Body contouring
 - Brow lift
 - Breast lift
 - Calf implants
 - Cheek/malar implants
 - Chemical peels (actinic keratosis is excluded, see related policy for additional information)
 - Chin or nose implants
 - Collagen and/or filler injections
 - Cool sculpting
 - Construction of clitoral hood
 - Dermabrasion

- Face or forehead lifts
- Facial bone reduction
- Facial feminization or masculinization surgery
- Feminization of torso
- Jaw reduction or contouring
- Hair removal and electrolysis
- Hair transplantation
- Lipectomy
- Lip enhancements
- Lip reduction
- Masculinization of torso
- Mastopexy
- Neck tightening
- Nipple reconstruction
- Nose implants
- Pectoral implants
- Pitch-raising surgery
- Removal of redundant skin (unless there is a functional impairment)
- Removal of benign skin lesions
- Rhinoplasty
- Scar removal
- Skin resurfacing
- Skin tag removal
- Tattoo removal
- Tracheal shave
- Vaginal rejuvenation procedures
- Voice modification

2. However, any of the above procedures may be considered medically necessary, and reconstructive in nature, when the following criteria are met:

- There is a documented physical and/or physiological abnormality that causes a functional impairment resulting in deviation from normal function of a tissue, or organ; AND
- The abnormality results in significantly impaired and/or limited capacity to perform physical and motor tasks, independent movement, and perform basic life functions; AND
- The abnormality is a result of a medical condition, accidental injury, or congenital defect; AND
- The proposed procedure can reasonably be expected to restore physiological functions.

Note: This policy is not applicable to breast reconstruction following surgical interventions for oncologic

indications including but not limited to implants, expanders, and nipple tattooing.

Note: The Health Plan complies with all Medicare National Coverage Determinations (NCDs) and applicable Local Coverage Determinations (LCDs) for all therapies, items, services, and/or procedures that are covered benefits under Medicare. If the coverage criteria in this policy conflicts with any NCDs or relevant LCD, the relevant document controls the application of services regardless of the version of the NCD or LCD listed in the reference section.

Please review the following policies for additional criteria and exceptions:

- Gender Affirmation
- Actinic Keratosis

CODING:

CPT Code	Description
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)
11400-11446	Excision, benign lesion including margins, except skin tag (unless listed elsewhere)
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion segmental face
15782	Dermabrasion, regional, other than face
15783	Dermabrasion; superficial, any site (eg, tattoo removal)
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal

CPT Code	Description
15792	Chemical peel, non-facial; epidermal
15793	Chemical peel, non-facial; dermal
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (Includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
17360	Chemical exfoliation for acne (eg, acne paste, acid)
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19316	Mastopexy
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
56620	Vulvectomy simple; partial

CPT Code	Description
58999	Unlisted procedure, female genital system (nonobstetrical)(vaginal rejuvenation)

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POLICY HISTORY:

Date	Description of Changes
7/29/ 2022	Added criteria to include the following: Chemical peels (actinic keratosis is excluded, see related policy for additional information). Added Actinic Keratosis to related policies. Added CPT code 17360.

POST-PAYMENT AUDIT STATEMENT:

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by THP at any time pursuant to the terms of your provider agreement.

DISCLAIMER:

This policy is intended to serve as a guideline only and does not constitute medical advice, any guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. This policy is intended to address medical necessity guidelines that are suitable for most individuals. Each individual's unique clinical situation may warrant individual consideration based on medical records. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and THP's professional judgment. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification, and utilization management guidelines. Unless otherwise noted within the policy, THP's policies apply to both participating and non-participating providers and facilities. THP reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by THP. THP has full and final discretionary authority for its interpretation and application. Accordingly, THP may use reasonable discretion in interpreting and applying this policy to health care services provided in any particular case.

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All revision dates:

9/13/2022, 1/17/2022