

MP.079 Cosmetic versus Reconstructive Services

Maryland Physicians Care considers **Reconstructive Services** medically necessary for either of the following:

- When the procedure is intended to primarily improve, restore, or maintain bodily function as a result of an infection or disease

OR

- The procedure is intended to correct a congenital disease or anomaly that has resulted in a significant functional impairment

Body contouring procedures, including but not limited to the following, are considered cosmetic and not medically necessary:

- Abdominoplasty
- Lipectomy, including Suction-Assisted Lipectomy (unless part of an approved procedure)
- Repair of Diastasis Recti.

Note: Coverage of reconstructive services is decided based on the applicable definition of medical necessity of the member's type of insurance and the Prior Authorization (PA), Medical Payment (MP) or Pharmacy (RX.PA) policy that governs the requested service.

Limitations

- When a medical problem results from covered or non-covered cosmetic procedures, medically necessary services required to treat the medical problem will be determined by the health plan
- Common, anticipated side effects of cosmetic surgery (e.g., nausea and vomiting which result in a prolonged hospital stay) are considered part of the cosmetic surgery procedure and are **not** eligible for additional coverage
- Benefits for reconstructive procedures include breast reconstruction following breast mastectomy, and reconstruction of the non-affected breast to achieve symmetry including breast prostheses and treatment of complications, are provided at the same level of care and services as required by the Women's Health and Cancer Rights Act of 1998. If the original service was not a covered benefit under the Maryland Physicians Care Medical Policy or applicable guidelines, (e.g., cosmetic, investigational, not a covered health service, etc.),

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benefits are limited to the treatment of the complication. Examples include but are not limited to: removal of a leaking, ruptured or defective silicone breast prosthesis. Benefits for replacement of the breast prosthesis are only available if the original prosthesis was considered "reconstructive" and not "cosmetic"

The following cosmetic procedures are **excluded** from coverage:

- Pharmacological regimens, nutritional procedures or treatments
- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures) for the improvement of appearance
- Skin abrasion procedures performed as a treatment for acne
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to reconstructive liposuction.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin
- Treatment for spider veins
- Sclerotherapy treatment of veins
- Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a physician for the treatment of gender dysphoria.
- Breast Reduction or Breast Lifts as a treatment to psychosocial complaints, psychological symptomatology or for the sole purpose of improving appearance
- Brachioplasty (arm lift), Buttock and Thigh Lift, Lipectomy and Liposuction when performed in the absence of a significant functional impairment or when not expected to improve a significant functional impairment

Coverage for Panniculectomy

- Panniculectomy is considered medically necessary when the following criteria are met ^(1,2):
 - Graded panniculus or panniculus that extends below the level of the pubic symphysis as documented in photographs with high-quality color image(s) of the physical/physiologic abnormality
 - Medical records (including consultations or any other pertinent information) documenting **ONE** or more of the following:
 - Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment
 - Nonhealing ulceration under panniculus, chronic maceration or necrosis of overhanging skin folds, recurrent or persistent skin infection under

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panniculus, intertriginous dermatitis or cellulitis or panniculitis, recurrent/chronic rashes, infections, cellulitis, or non-healing ulcers, that don't respond to conventional treatment (e.g., dressing changes; topical, oral or systemic antibiotics, corticosteroids or antifungals) for a period of 3 – 6 months

- Functional impairment, such as difficulty ambulating, or limitations in physical activity interfering with daily living activities, that requires physical therapy for a period of 3 – 6 months

AND

- Presence of functional deficit or impairment despite appropriate treatment due to a severe physical deformity or disfigurement resulting from the pannus through significant* weight loss (medically supervised diet or bariatric surgery) with stable weight management for at least 6 months ⁽³⁾

*Significant weight loss varies based on the individual clinical circumstances and may be documented as any **ONE** of the following:

- Reaches a body mass index (BMI) ≤ 30 kg/m²
 - Has documented > 100-pound weight loss
 - Has achieved a weight loss $\geq 40\%$ of the excess body weight prior to the individual's weight loss program or surgical intervention
- If patients have had bariatric surgery, they are at least 18 months post-operative and have documented stable weight for at least 6 months
 - Surgery is expected to restore or improve the functional deficit or deformity
 - Panniculectomy is considered medically necessary as an adjunct to a medically necessary surgery when needed for exposure in extraordinary circumstances
 - Panniculectomy is considered cosmetic and not medically necessary when performed for the following indications:
 - For any other condition that does not meet the InterQual® criteria
 - In conjunction with abdominal or gynecologic surgery, including but not limited to hernia repair, bariatric surgery, C-section, or hysterectomy, unless the patient meets the InterQual® CP: Procedures, Panniculectomy, Abdominal criteria
 - When performed for primarily cosmetic purposes.

NOTE: Certain patient characteristics (≥ 65 years old, BMI ≥ 30 kg/m², active smoking status and having diabetes mellitus) have been correlated with an increase in risk of postoperative complications following a panniculectomy such as wound infection, dehiscence, seroma, and venous thromboembolism ⁽²⁾.

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Coverage for Liposuction for Lymphedema ⁽⁴⁻⁶⁾

- Considered medically necessary when the following criteria are met:
 - Performed in the treatment of lymphedema (i.e., related to surgical mastectomy)
 - Presence of significant functional impairment or medical complication (i.e., difficulty ambulating or performing daily functions)
 - Procedure is expected to improve functional impairment (i.e., volume reduction resulting in significant mobility improvement)
 - Patient has not responded to conservative treatment (i.e., treatment with compression garments, complex/complete decongestive therapy (CDT) or manual lymph drainage) for at least 3 consecutive months
 - Treatment plan requires patient to wear compression garments as instructed and continue postoperative treatment to maintain benefit

NOTE: Suction-assisted lipectomy used in conjunction with a panniculectomy is considered integral to the primary procedure and will not be separately reimbursed.

Coverage for Brachioplasty (arm lift), Buttock and Thigh Lift ^(7,8)

- Considered medically necessary when the following criteria are met:
 - Presence of significant functional impairment (i.e., excessive skin that interferes with daily living or causes persistent cellulitis, dermatitis or skin ulcerations) despite appropriate treatment
 - Procedure is expected to improve functional impairment

Coverage for procedures for excision of redundant or excessive skin of other anatomical areas (e.g., neck, upper and lower extremities, buttocks)

- Considered medically necessary when all of the following criteria are met:
 - Presence of a functional deficit due to a severe physical deformity or disfigurement resulting from the redundant or excessive skin
 - The surgery is expected to restore or improve the functional deficit
 - The redundant or excessive skin is demonstrated on preoperative photographs
 - The redundant or excessive skin is interfering with activities of daily living
 - For areas other than the face, there is evidence, including photographs, that the redundant or excessive skin is causing persistent intertriginous dermatitis, cellulitis, or skin ulceration, which is refractory to at least three (3) months of medical management, including all applicable treatments. In addition to good hygiene practices, applicable treatment should include topical antifungals; topical and/or systemic corticosteroids; and/or local or systemic antibiotics.

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These procedures are considered cosmetic in nature and not medically necessary when:

- The surgery is being performed to treat psychological symptomatology or psychosocial complaints, in the absence of significant physical, objective signs
- The surgery is being performed for the primary purpose of improving appearance
- The suction-assisted lipectomy is performed alone and not as part of another medically necessary procedure

Background

Cosmetic procedures are procedures or services that change or improve appearance without significantly improving physiological function. A procedure is considered to be a cosmetic procedure when it does not meet the reconstructive criteria in the reconstructive procedures section above. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

A functional, physical or physiological impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas:

- physical and motor tasks
- independent movement
- performing basic life functions

Applicable Codes

The following list of procedure codes may not be all inclusive. Listing of a code in this policy does not imply that the service is a covered/non-covered health service. Benefit coverage is determined by the member's benefit plan document in effect at the time of service and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Maryland Physicians Care Policies and Guidelines may apply.

The following codes are considered cosmetic and are not covered:

Code	Description
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less

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11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., 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 (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15786	Abrasion; single lesion (e.g., 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
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
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
17380	Electrolysis epilation, each 30 minutes
21270	Malar augmentation, prosthetic material
69090	Ear piercing
69300	Otoplasty, protruding ear, with or without size reduction
J0591	Injection, deoxycholic acid, 1 mg
<i>The following codes require review to determine whether they are cosmetic or reconstructive:</i>	
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less

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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)
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
15570	Formation of direct or tubed pedicle, with or without transfer; trunk
15572	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs

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15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15730	Midface flap (i.e., zygomaticofacial flap) with preservation of vascular pedicle(s)
15731	Forehead flap with preservation of vascular pedicle (e.g., axial pattern flap, paramedian forehead flap)
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (i.e., buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk
15736	Muscle, myocutaneous, or fasciocutaneous flap; upper extremity
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity
15740	Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel
15756	Free muscle or myocutaneous flap with microvascular anastomosis
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock

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15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
15877	Suction assisted lipectomy; trunk [when specified as abdominal liposuction]
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue [when specified as other abdominoplasty, excision excessive skin and subcutaneous tissue, including lipectomy, of abdomen]
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with implant
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21181	Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial

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21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (e.g., micro-ophthalmia)
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach

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21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach
21275	Secondary revision of orbitocraniofacial reconstruction
21295	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach
21296	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach
21299	Unlisted craniofacial and maxillofacial procedure
28344	Reconstruction, toe(s); polydactyly
30540	Repair choanal atresia; intranasal
30545	Repair choanal atresia; transpalatine
30560	Lysis intranasal synechia
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)
L8600	Implantable breast prosthesis, silicone or equal
L8607	Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies
Q2026	Injection, Radiesse, 0.1 ml
Q2028	Injection, sculptra, 0.5 mg

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Disclaimer

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Attachment A

The following list contains additional examples of procedures and services considered to be cosmetic in nature and therefore **not** covered, except when indicated in the identified PA, MP, or RX.PA Policy in Column III.

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This list should not be considered inclusive. The following codes for treatments and procedures applicable to this policy are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

I	II	III
Procedure	Codes for Procedures in Column NOT covered	Exception for Coverage
Acne, treatment of acne cysts and Acne, comedone extraction/treatment	10040 Acne surgery (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules) 17340 Cryotherapy (CO2 slush, liquid N2) for acne 17360 Chemical exfoliation for acne (e.g., acne paste, acid)	17340, 17360 covered with pre-authorization
Actinic keratosis, destruction, unless suspicious of malignancy	Informational only No codes for configuration because of potential medical necessity	
Age spot treatments (SEE : Skin lesions, excision of benign)		
Alopecia treatment (SEE : Hair Transplant)		This may be reviewed on a case by case basis for medical necessity.
Arm, forearm, hand lift (SEE : Lipectomy)		
Birthmark/ blemish treatment (SEE : Skin lesions, excision of benign)		

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Procedure	Codes for Procedures in Column NOT covered	Exception for Coverage
Blepharoplasty lower lid	15820 Blephroplasty, lower eyelid lid 15821 Blephroplasty, lower eyelid lid with extensive herniated fat pad	
Body contouring after major weight loss for men (SEE : Lipectomy)		
Body lift (SEE : Lipectomy)		
Body piercing	No specific code for this	
Botox treatments		Pre-authorization is required for: OnabotulinumtoxinA (Botox®), AbobotulinumtoxinA (Dysport™), RimabotulinumtoxinB (Myobloc®), and IncobotulinumtoxinA (Xeomin®)
Breast asymmetry, correction of. <i>Except in the case of breast cancer</i>		SEE: MP.046 - Breast Reconstruction
Breast reconstruction. <i>Except in the case of breast cancer</i>		SEE: MP.046 - Breast Reconstruction
Breast augmentation/lift/implants.		SEE: MP.046 Breast Reconstruction

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Procedure	Codes for Procedures in Column NOT covered	Exception for Coverage
<i>Except in the case of breast cancer</i>		
Breast reduction		
Breast repositioning		SEE: MP.046 Breast Reconstruction
Brow lift/ptosis repair		
Buttock lift (SEE: Lipectomy)		
Cheek implant (SEE: Malar (facial) implants)		
Chemical peel	15788 Chemical peel, facial; epidermal 15789 Chemical peel, facial; dermal 15792 Chemical peel, nonfacial; epidermal 15793 Chemical peel, nonfacial; dermal	15789, 15792, 15793 covered with prior authorization.
Chest wall deformity, congenital (pectus excavatum, pectus carinatum) when asymptomatic	No specific code for this	Treatment for pectus excavatum is considered medically necessary when the member has a Haller score of 3.25 or higher on Computed Tomography (CT) scan. Treatment for pectus carinatum is considered

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		medically necessary when member has symptoms indicating medical necessity for surgery which include: severe shortness of breath on minimal exertion, reduced endurance, and exercise-induced asthma.
Chin implant or surgery for deformity, not cause by trauma or accidental injury (SEE: Genioplasty)		
Collagen replacement therapy: injections or implants	11950 Subcutaneous injection of filling material (e.g. collagen): 1cc or less 11951 1.5 to 5 cc 11952 5.1 to 10 cc 11954 10 cc or more	
Comedone acne extraction (SEE: Acne)		
Congenital abnormalities without functional impairment	No specific code for this	
Dental congenital abnormalities	No specific code for this	
Dermoid cyst (when not medically necessary)	30124 Excision of dermoid cyst, nose: simple, skin, subcutaneous	Covered. Pre-authorization required for non-participating providers only.

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Procedure	Codes for Procedures in Column NOT covered	Exception for Coverage
Dermabrasion	15780 Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis) 15781 Dermabrasion; segmental, face 15782 Dermabrasion; regional, other than face 15783 Dermabrasion; superficial, any site, (e.g., tattoo removal)	
Dermal filler and volume producing agents (i.e., Sculptra, Radiesse)	G0429 Derm filler injection for treatment facial lypodystrophy Q2026 Injection, Radiesse 11950 Subcutaneous injection of filling material (e.g., collagen); 1 cc or less 11951 Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc 11952 Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc 11954 Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc	G0429 & Q2026 covered with pre-authorization
Dermoscopy	No specific code for this	
Ear piercing	69090 Ear piercing	
Ear protrusion correction (SEE: Otoplasty)		

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Procedure	Codes for Procedures in Column NOT covered	Exception for Coverage
Electrolysis epilation /hair removal (SEE: Hair Removal)		
Excision of redundant (excess) skin and subcutaneous tissue of the hips, thighs, buttocks, arms and other anatomical areas when there is not a functional physical impairment (SEE: Lipectomy)		
Excision/surgical planing of skin of nose for rhinophyma (SEE: Rhinophyma)		
Eyelid surgery (Blepharoplasty, brow lifts, ptosis repair)		
Face lift or related procedures to diminish the aging process (SEE: Rhytidectomy)		
Fat graft, unless an integral part of another covered procedure		
Forehead lift (SEE: Rhytidectomy)		
Frown Line reduction (Refer to Glabella)		

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Genioplasty (SEE : Rhytidectomy and Lipectomy)	21120 Genioplasty: augmentation (autograft, allograft, augmentation)	Covered with pre-authorization
Glabella/Glabelloplasty (frown lines), excision/correction (SEE : Rhytidectomy)	21137 Reduction forehead; contouring only 21138 Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft) 21139 Reduction forehead; contouring and setback of anterior frontal sinus wall	Covered with pre-authorization
Gynecomastia reduction/treatment		
Hair Removal (hirsutism)	17380 Electrolysis epilation, each 30 minutes	
Hair Transplant (Hairplasty) or repair of any congenital or acquired hair loss, including hair analysis	15775 Punch graft for hair transplant; 1 to 15 punch grafts 15776 Punch graft for hair transplant; more than 15 punch grafts	
Hemangioma treatment <i>Except when atypical or causing functional limitation (i.e. affects vision, breathing, hearing, ability to eat,</i>	17106 Destruction of cutaneous vascular proliferative lesions(e.g., laser technique); less than 10 sq cm	Covered with pre-authorization

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<i>bleeding, ulceration, and/or infection.</i>		
Hip Lift (SEE: Lipectomy)		
Hyperhidrosis surgery including endoscopic transthoracic sympathectomy (ETS), sympathectomy (radial artery, ulnar nerve, superficial palmar arch), video assisted thoracic sympathectomy (VATS)		SEE: MP.036 - Iontophoresis
Injectable fillers (SEE: Dermal fillers)		
Insertion or injection of prosthetic material to replace absent adipose tissue. <i>Except for breast cancer</i>		SEE: MP.046 - Breast Reconstruction
Keloid scar treatment (SEE: Scar Revision)		
Labial reduction / labiaplasty	No specific code for this	
Laser band-aid face lift	No specific code for this	
Laser facial resurfacing (SEE: Dermabrasion)	No specific code for this	
Laser hair removal (SEE: Hair Removal)		
LAVIV™ (azfibrocel-T) injections	No specific code for this	

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Procedure	Codes for Procedures in Column NOT covered	Exception for Coverage
Leg lift (SEE: Lipectomy)		
Lipectomy (including suction lipectomy)	<p>15832 Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh</p> <p>15833 Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg</p> <p>15834 Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip</p> <p>15835 Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock</p> <p>15836 Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm</p> <p>15837 Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand</p> <p>15838 Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad</p> <p>15839 Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area</p>	15832 through 15839 covered with pre-authorization.
Liposuction unless an integral part of another covered procedure	<p>15876 Suction assisted lipectomy; head and neck</p> <p>15877 Suction assisted lipectomy; trunk</p>	

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	15878 Suction assisted lipectomy; upper extremity 15879 Suction assisted lipectomy; lower extremity	
Malar (facial) implants	No specific code for this	
Mastopexy (breast lift for pendulous breasts)		SEE: MP.046 - Breast Reconstruction
Mentoplasty (SEE: Genioplasty)		
Moles /nevi, excision <i>Except when medically necessary when there is clinical suspicion for pre-cancerous or cancerous lesions.</i>	No specific code for this	
Neck tuck or lift (SEE: Lipectomy and Rhytidectomy)		
Moon face correction (as a result of corticosteroid therapy)	No specific code for this	
Nasal septum cartilage graft	20912 Cartilage graft, nasal septum	Covered with pre-authorization.
Obesity surgery		SEE: PA.040 Bariatric Procedures
Otoplasty	69300 Otoplasty, protruding ear, with or without size reduction	Covered with pre-authorization

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Pectus excavatum repair when asymptomatic (SEE: Chest wall deformity)		
Permanent makeup (SEE: Tattoo)		
Port wine stain treatment <i>Except when atypical or causing functional limitation (i.e. affects vision, breathing, hearing, ability to eat, bleeding, ulceration, and/or infection. (SEE: Hemangioma treatment)</i>		
Radial keratotomy when defect can be corrected with lenses	65771 Radial Keratotomy	
Rhinoplasty	30400 Rhinoplasty; primary; lateral & alar cartilages and/or elevation of nasal tip 30410 Rhinoplasty; complete; external parts including bony pyramid; lateral & alar cartilages &/or elevation of nasal tip. 30450 Rhinoplasty, secondary, major revision	SEE: MP.038 - Septoplasty/Rhinoplasty Pre-auth required for non-participating providers only.
Refractive keratoplasty/eye surgery (LASIK, PTK)	65760 Keratomileusis (LASIK) 65765 Keratophakia 65767 Epikeritoplasty	Covered with pre-authorization
Rhinophyma treatment/excision	30120 Excision or surgical planing of skin of nose for rhinophyma	Covered. Pre-authorization required for non-participating providers only.

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Procedure	Codes for Procedures in Column NOT covered	Exception for Coverage
Removal of unwanted/excessive hair growth (SEE: Hair Removal)		
Rhytidectomy (face, chin, neck, browlift)	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	
Rosacea, treatment of (including erythema, telangiectasia) <i>Except when atypical or causing functional limitation</i>	Codes are the same as Hemangioma	
Salabrasion (tattoo removal) (SEE: Tattoo)		
Scar revision <i>Except when atypical or causing functional limitation (i.e. affects vision, breathing, hearing, ability to eat, bleeding, ulceration, and/or infection.</i>	15786 Abrasion; single lesion (e.g., keratosis, scar) 15787 Abrasion; each additional four lesions or less	Burn scars in children when medically necessary
Sclerosing of Spider Veins		

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(SEE: Spider vein removal/repair)		
Septoplasty		SEE: MP.038 – Septoplasty/Rhinoplasty
Septorhinoplasty		SEE: MP.038 - Septoplasty- Rhinoplasty
Skin discoloration (including dyschromia, and treatment)	No specific code for this	
Skin lesions, excision of benign <i>Except when atypical or causing functional limitation (i.e. affects vision, breathing, hearing, ability to eat, bleeding, ulceration, and/or infection; OR Except when medically necessary when there is clinical suspicion for pre-cancerous or cancerous lesions.</i>	Informational only No codes for configuration because of potential medical necessity	
Skin removal for excessive/redundant skin. <i>Except for breast cancer (SEE: Lipectomy)</i>		SEE: MP.046 - Breast Reconstruction
Skin rejuvenation and resurfacing (SEE: Dermabrasion)	No specific code for this	

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Spider vein removal/repair, including telangiectasia and stellate angioma	36468 Single or multiple injections of sclerosing solutions, spider veins (telangiectasia), limb or trunk	Covered with pre-authorization.
Skin tag removal, Except when atypical or causing functional limitation (i.e. affects vision, bleeding, ulceration, and/or infection.	Informational only No codes for configuration because of potential medical necessity	
Subcutaneous injection of filling material (e.g. Restylane, Collagen, Hyaluronic acid) (SEE: Dermal fillers)		Hyaluronic Acid Products
Surgical repair of inverted nipple		SEE: MP.046 - Breast Reconstruction
Tattoo (decorative or self induced) removal/treatment	No specific code for this	SEE: MP.046 - Breast Reconstruction
Thigh lift (SEE: Lipectomy)		
Temporal Mandibular Joint (TMJ), non surgical treatment		SEE: MP.016 - TMJ
Tissue expansion, when not medically necessary		SEE: MP.046 - Breast Reconstruction
Torn earlobe repair	No specific code for this	

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Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)	49250 Umbilectomy, omphalectomy, excision of umbilicus	Covered with pre-authorization.
Varicose veins, removal of spider veins (telangiectasia)		
Voice lifting procedures (To restore voice to youthful quality, implants, injections of fat or collagen)		SEE MP.112 – Laryngeal Inj for Vocal Cord Augmentation
XEOMIN® (incobotulinumtoxinA) injections when used to improve the appearance of glabellar lines		OnabotulinumtoxinA (Botox®), AbobotulinumtoxinA (Dysport™), RimabotulinumtoxinB (Myobloc®), and IncobotulinumtoxinA (Xeomin®)