



PARAMOUNT

ADVANTAGE | ELITE | HMO  
INDIVIDUAL MARKETPLACE |  
PROMEDICA MEDICARE  
PLAN | PPO

# Cosmetic and Reconstructive Surgery

Policy Number: PG0104

Last Review: 12/23/2021

## GUIDELINES

- **This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.**
- **Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.**
- **This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.**

## SCOPE

Professional

Facility

## DESCRIPTION

Cosmetic services are defined as services that are used to improve a person's appearance, but not their functionality. Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Their condition is not impairing their ability to participate in daily activities and routines.

Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, burns, infection, tumors, or disease. It is generally performed to improve, restore, or maintain bodily function, but may also be done to approximate a normal appearance.

Reconstructive procedures may be considered medically indicated when:

- There is documented evidence of physical functional impairment caused by congenital defects, developmental abnormalities, trauma, burns, infection, tumors, or disease after failure of conservative therapy (unless conservative therapy is not standard of care for the condition, or is contraindicated); OR
- Services are provided primarily to correct documented progressive impairment of physical function that interferes with the performance of activities of daily living,

The conditions of impairment must meet the definition of reconstructive services designated by each individual policyholder terms, conditions, exclusions and limitations contract for whom a procedure is being considered.

## POLICY

**The purpose of this policy is to supplement coverage guidance for surgical procedures with cosmetic aspects that may not be contained in a separate clinical policy. If there is a discrepancy between this policy and a member's plan of benefits, then the provision of the benefits will govern and rule.**

- **Reconstructive Services are covered when medical indications support medical necessity**
- **Cosmetic Services performed solely to improve one's appearance and/or self-esteem are considered not medically necessary and therefore not covered**

**Paramount will review procedures intended for correcting complications from a cosmetic procedure, whether the original procedure was medically necessary or a non-covered service. In order for these corrections to be considered medically necessary, the subsequent surgery needs to be reconstructive in nature. Paramount considers complications arising from a non-covered**

service as well as from a medically necessary service when the treatment of the complication itself is medically necessary.

Reconstructive surgery may be eligible for coverage due to congenital defects, developmental abnormalities, trauma, burns, infection, tumors, or disease of the involved part when a functional impairment is present.

Some reconstructive procedures require prior authorization. A provider must refer to the Paramount prior authorization list and specific medical policies in reference to specific procedures as indicated below (this list may not be all-inclusive).

This medical policy does NOT address Gender Reassignment (Transgender Services); refer to Medical Policy PG0311 Gender Reassignment Surgery related to Cosmetic Exceptions.

For codes NOT in another specific medical policy:

HMO, PPO, Individual Marketplace

Procedures 15769, 15839 do not require a prior authorization.

Procedures 0419T, 0420T, 0437T, 15773, 15774, 15775, 15776, 15786, 15787, 15819, 15824, 15825, 15826, 15828, 15829, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15876, 15878, 15879, 17380, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21256, 21260, 21261, 21263, 21267, 21268, 21280, 21282, 30120, 69090, G0429, L8607, Q2026, & Q2028 are non-covered

Advantage

Procedures 15876, 15878, & 15879, require a prior authorization.

Effective 12/01/2021 procedures 15773 and 15774 require a prior authorization.

Coverage is considered medically necessary when the primary purpose is to preserve or improve a physical functional impairment of an abnormal body part caused by illness, trauma, or a congenital defect, e.g. breast reconstruction, Gender Dysphoria and Gender Reassignment Surgery.

Procedures 15769, 15786, 15787, 15839, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21256, 21260, 21261, 21263, 21267, 21268, 21280, 21282, & 30120 do not require a prior authorization.

Procedures 0419T, 0420T, 0437T, 15775, 15776, 15819, 15824, 15825, 15826, 15828, 15829, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 17380, 69090, G0429, L8607, Q2026, & Q2028 are non-covered

Elite/ProMedica Medicare Plan

Procedures 15769, 15828, 15829, 15839, G0429, Q2026, & Q2028 do not require a prior authorization.

Procedures 0419T, 0420T, 0437T, 15773, 15774, 15775, 15776, 15786, 15787, 15819, 15824, 15825, 15826, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15876, 15878, 15879, 17380, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21256, 21260, 21261, 21263, 21267, 21268, 21280, 21282, 30120, 69090, & L8607 are non-covered.

This policy addresses many common procedures; however, it does not address all procedures that might be considered cosmetic surgery excluded from coverage. Paramount reserves the right to deny coverage for other procedures that are cosmetic and not medically necessary.

**COVERAGE CRITERIA**

## HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan, Advantage

Paramount Member's may not be eligible under their Benefits of Coverage Plan for procedures performed for cosmetic purposes (to improve or change appearance or self-esteem). Please refer to the Member's individual Benefits of Coverage Plan for the specific terms of their particular benefit plan.

Cosmetic and reconstructive surgical procedures may be considered medically necessary for any of the following indications, and supporting language is contained in the member's contract, not an all-inclusive listing:

- There is documented evidence of a functional or physical impairment causing deviation from normal function of a tissue or organ due to congenital defects (i.e. cleft lip or cleft palate), developmental abnormalities (congenital defect birth abnormality), trauma, burns, infection, tumors, or disease; AND
  - After failure of conservative therapy (unless conservative therapy is not standard of care for the condition, or is contraindicated); AND
    - The requested procedure can reasonably be expected to improve/restore bodily functions, to correct significant deformity, and/or resolve the associated medical complications; OR
    - The requested procedure is intended to correct congenital or developmental anomalies that have resulted in significant functional impairment that interferes with the performance of activities of daily living OR
- For post mastectomy breast reconstruction; OR
- Repair of cleft lip and palate is considered reconstructive regardless of functional limitations.

A provider must refer to the Paramount prior authorization list and specific medical policy in reference to specific procedures. There are certain reconstructive services that require prior authorization for reimbursement. These services will be reviewed for medical necessity to ensure they do not fall within the guidelines of cosmetic services. If the service is allowed with prior authorization but is denied because prior authorization was refused, the service will be denied and the member cannot be held financially liable.

Paramount 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.

Psychiatric and/or emotional distress are not considered medically necessary indications for cosmetic procedures.

Paramount may not cover complications of noncovered cosmetic and reconstructive procedures including, but may not be limited to, the following:

- Breast reconstruction following elective breast augmentation (enlargement)
- Complications of any piercing (eg, abscess, infection) of any body part (eg, brow, ear, genitalia, lip, navel, nipple, nose, etc.)
- Ear reconstruction for torn auricle or earlobe following any elective cosmetic procedure (eg, ear piercing, gauging or plugging)

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.

HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan, Advantage	
<u>The following surgeries and procedure may be considered Cosmetic - Non-Covered Services, when medical indications as indicated above are not met, not an all-inclusive listing</u>	
<b>Procedures</b>	<b>Refer to the Corresponding Medical Policy if indicated for additional criteria, that must be met in order for certain procedures to be considered medically</b>

	indicated, may not be all-inclusive	
<p><b>Abdominoplasty</b> A tummy tuck, also known as abdominoplasty, removes excess fat and skin and restores weakened muscles to create a smoother, firmer abdominal profile.</p>	PG0299 Abdominoplasty, Panniculectomy and Liposuction	
<b>Adipose-Derived Regenerative Cell (ADRC) Therapy (i.e. Habeo Cell Therapy)</b>		
<b>Aesthetic alteration of the female genitalia (e.g., hymenoplasty, inverted V hoodoplasty, labiaplasty, and mons pubis pexy)</b>		
<b>Aesthetic operations on umbilicus</b>		
<b>Age spot treatments</b>		
<b>Birthmark/blemish treatment</b>		
<b>Blepharoplasty (eyelid surgery)</b>	PG0007 Blepharoplasty, Reconstructive Eyelid Surgery, & Brow Lift	
<p><b>Body Lifts</b> Improves the shape and tone of the underlying tissue that supports fat and skin. Excess sagging fat and skin are also removed and the procedure(s) can improve a dimpled, irregular skin surface. A body lift may include these areas: upper arm, from the underarm region to the elbow; abdominal area (locally or extending around the sides and into the lower back area); buttocks; thigh (the inner, outer, or posterior thigh, or the thigh's circumference). In cases where skin elasticity is poor, body lift technique along with liposuction may be recommended</p>		
<p><b>Botox for wrinkles</b> The cosmetic form of botulinum toxin is a popular injectable that temporarily reduces or eliminates facial fine lines and wrinkles. The most commonly treated areas are frown lines, forehead creases, crow's feet near the eyes. Several other areas have been treated such as thick bands in the neck, thick jaw muscles, lip lines and gummy smiles. OnabotulinumtoxinA (Botox®), AbobotulinumtoxinA (Dysport™), RimabotulinumtoxinB (Myobloc®), and Incobotulinum</p>		
<p><b>Breast augmentation (enlargement), elective</b> Involves using breast implants or fat transfer to increase the size of the breasts. This procedure can restore breast volume lost after weight reduction or pregnancy, achieve a more rounded breast shape or improve natural breast size asymmetry (enhance self-image and self-confidence).</p>	PG0144 Breast Reconstruction Services	
<p><b>Breast Implant Revision</b> The goal of breast implant revision surgery is to replace old breast implants with new implants. Often the goal is also to change or improve the appearance of the breasts while updating the implant material, which could include: a concurrent breast lift or reduction; reshaping the breast implant pocket to reposition the implant on the chest; either increasing or decreasing the size, shape, style of the breast implant.</p>	PG0012 Breast Implant Removal and Reimplantation	
<p><b>Breast Implant Removal</b> The goal of breast implant removal surgery is to remove the breast implant from breast augmentation or breast reconstruction patients. During these procedures, the surgeon may also remove silicone material from implant leaks and the breast capsule, which is the scar tissue that forms after the placement of a breast implant.</p>	PG0012 Breast Implant Removal and Reimplantation	
<p><b>Breast lift (mastopexy)</b> Raises the breasts by removing excess skin and tightening the surrounding tissue to reshape and support the new breast contour. A breast lift can rejuvenate the figure with a breast profile that is more</p>	PG0144 Breast Reconstruction Services	

<p>youthful and uplifted. A woman's breasts often change over time, losing their youthful shape and firmness. These changes and loss of skin elasticity can result from: pregnancy, breastfeeding, weight fluctuations, aging, gravity and heredity.</p>		
<p><b>Breast reduction</b>  Is a procedure to remove excess breast fat, glandular tissue and skin to achieve a breast size more in proportion with the body and to alleviate the discomfort associated with excessively large breasts (macromastia)? Although breast reduction is often performed to address medical issues, patients who do not have the symptoms of macromastia but are unhappy with the size of their breasts can still pursue breast reduction as an aesthetic procedure. Patients choosing to undergo breast reduction surgery for cosmetic reasons may cite any number of factors, including social stigmas and wardrobe concerns.</p>	PG0054 Reduction Mammoplasty	
<p><b>Calf augmentation (restore leg contour)</b>  Calf implants are used to create fullness in the lower leg. Similarly, pectoral implants that are used to build the chests of men with Poland's syndrome, can also be used to "bulk out" the existing pectoral muscles of healthy men.</p>		
<p><b>Buttock lift or augmentation</b>  Is used to improve the contour, size and/or shape of the buttocks. This is done through the use of buttock implants, fat grafting or sometimes a combination of the two. Buttock implants are silicone filled devices that are surgically placed deep within the tissues of the buttock. Buttock augmentation through the use of fat grafting involves the transfer of fat from one area of the body into tissues of the buttocks. This technique is sometimes referred to as a Brazilian Butt Lift.</p>		
<p><b>Canthopexy or Canthoplasty (lower eyelid tightening)</b></p>		
<p><b>Cheek implant (malar implant/augmentation) (eg, Juvederm, Restylane)</b>  The goal of cheek augmentation is to add volume or life to the cheeks. Some people are bothered by their cheeks losing volume, or even sagging with age. Others never develop the desired volume in their cheeks and are bothered by cheeks that may be considered flat or thin. Valid surgical options for augmenting and enhancing the cheeks are fat grafting/transfer (where a patient's own fat is used) or the use of solid cheek implants. A nonsurgical option is the use of injectable fillers (dermal fillers) to enhance the cheeks.</p>		
<p><b>Chemical peels (chemical exfoliation) (Treatments aimed solely at improving personal appearance/acne treatments)</b></p>	PG0348 Acne Treatments	
<p><b>Chin implant (genioplasty, mentoplasty)</b></p>	PG0056 Surgical Treatments for Obstructive Sleep Apnea (OSA)	
<p><b>Collagen implant</b></p>	PG0497 Urinary Incontinence/ Voiding Dysfunction Treatments and Devices PG0348 Acne Treatments PG0144 Breast Reconstruction Services	
<p><b>Collagenase clostridium histolyticum-aaes (Qwo, Endo Aesthetics LLC) injection for treatment of moderate to severe cellulite in the buttocks</b></p>		
<p><b>Cool sculpting (may also be known as cryolipolysis or fat freezing)</b></p>	Cosmetic for all indications, Experimental, investigational, and/or unproven for all indications.	



<p>Correction of diastasis recti abdominis</p> <ul style="list-style-type: none"> <li>• Repair of a diastasis recti, defined as a thinning out of the anterior abdominal wall fascia, not medically necessary because, according to the clinical literature, it does not represent a "true" hernia and is of no clinical significance.</li> <li>• Repair of a true incisional or ventral hernia is considered medically necessary.</li> </ul>	
Correction of inverted nipple, unless related to cancer surgery	PG0144 Breast Reconstruction Services
Cryotherapy for benign skin lesions	PG0348 Acne Treatments
Dermabrasion (acne scarring, fine wrinkles, rhytids, and tattoo removal)	PG0348 Acne Treatments
Deoxycholic acid injection (e.g., Kybella)	
Ear or body piercing	Cosmetic for all indications
Earlobe repair: Repair (e.g., tear) of a traumatic injury is considered medically necessary. Earlobe repair to close a stretched pierce hole, in the absence of a traumatic injury, is considered cosmetic.	
Electrolysis or laser hair removal	
Excision of excessive skin (lipectomy/liposuction) of thigh (thigh lift, thighplasty), leg, hip, buttock, arm (arm lift, brachioplasty), forearm or hand, submental fat pad, or other areas.	PG0299 Abdominoplasty, Panniculectomy and Liposuction
Considered cosmetic when submental fat in adults (i.e., double chin) treated with Kybella T M (deoxycholic acid) injections.	
<p>Female Sexual Dysfunction (FSD)</p> <ul style="list-style-type: none"> <li>• Bibliotherapy</li> <li>• Biothesiometry</li> <li>• Botulinum toxin</li> <li>• Female erectile devices (e.g., Eros clitoral stimulation device)</li> <li>• Gene therapy</li> <li>• Growth factor therapy</li> <li>• Hyaluronic acid</li> <li>• Laser therapy (e.g., Micro-ablative carbon dioxide laser)</li> <li>• Oxytocin</li> <li>• Percutaneous tibial nerve stimulation</li> <li>• Phosphodiesterase type 5 inhibitors (e.g., sildenafil, tadalafil, and vardenafil)</li> <li>• Progesterone</li> <li>• Radiofrequency thermal therapy (e.g., the ThermiVa procedure, and the Viveve procedure)</li> <li>• Regenerative medicine</li> <li>• Sacral neuromodulation</li> <li>• Stem cell-based therapies</li> <li>• Testosterone therapy (implant or injection)</li> <li>• Topical lidocaine</li> <li>• Transcranial direct current</li> <li>• Vaginal electrical stimulation</li> </ul> <p>Nonsurgical vaginal rejuvenation can help to reverse changes in a women's genitalia that are caused by childbearing, hormonal changes and/or aging. Changes that can impact a woman's quality of life include vaginal laxity, stress urinary incontinence, loss of vaginal lubrication, a decrease in erotic sensation and loss of tone of the labia majora. Devices that have been developed to treat some or all these changes uses radiofrequency or laser energy to induce collagen tightening. Fillers are sometimes used to inject in the clitoris and/or "G-</p>	

spot.” The field of nonsurgical female genital rejuvenation is growing as the change women experience receive greater attention		
Forehead reduction, contouring, contouring and application of contouring material or bone graft (includes obtaining autograft), and contouring and setback of anterior frontal sinus wall. A brow lift, also known as a forehead lift, reduces wrinkles, improves frown lines and places the eyebrows in a youthful position. Other cosmetic procedures that may be performed with a brow lift include the following: upper and or lower eyelid surgery (blepharoplasty); face-lifting; skin resurfacing techniques.	PG0226 Orthognathic Surgery	
Gynecomastia surgery Reduces breast size in men, flattening and enhancing the chest contours. Plastic surgery to correct gynecomastia is technically called reduction mammoplasty. Gynecomastia can cause emotional discomfort and impair self-confidence. Some men may even avoid certain physical activities and intimacy simply to hide their condition.	PG0221 Mastectomy for Gynecomastia	
Hair transplants/replacements (a variety of techniques, including punch grafts)		
Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall		
Injectable fillers (Dermal Fillers) (i.e. Radiesse, Sculptra) May be considered reconstructive when: <ul style="list-style-type: none"> <li>• Injectable dermal fillers (e.g., Radiesse®, Sculptra®) used to sculpt or smooth body and/or facial contours in cases of human immunodeficiency virus (HIV)-associated lipodystrophy in the presence of a functional impairment.</li> <li>• Laryngeal Augmentation System, or Laryngeal Augmentation Implant for indications of vocal fold medialization and vocal fold insufficiency in accordance with FDA labeling (e.g. Radiesse® Laryngeal Implant; Juliesse™ Laryngeal Implant).</li> </ul> Considered cosmetic when injectable dermal fillers used to sculpt or smooth body and/or facial contours (e.g. Radiesse®, Sculptra®) for all other indications		
Intense pulsed light laser for facial redness	PG0308 Pulsed Dye Laser Therapy for Cutaneous Vascular Lesions	
Keloids: Repair of keloids is considered medically necessary if they cause pain or a functional limitation. Note: For repair of keloids that do not cause pain or functional impairment, exceptions to cosmetic surgery exclusion may apply. May be considered reconstructive when: <ul style="list-style-type: none"> <li>• Ulceration or infection with or without sinus tracts;</li> <li>• Extremely large, painful keloid associated with stretching;</li> <li>• Rapid growth of the keloid interferes with normal function.</li> </ul> Considered cosmetic when removal of small keloid which does not interfere with normal function.		
Lacrimal gland resuspension for lacrimal gland prolapse		
Laser skin resurfacing (also known as laser peel, laser vaporization) to reduce wrinkles, scars and blemishes including but not limited to the following: <ul style="list-style-type: none"> <li>• Acne scarring</li> <li>• Age spots/brown spots</li> <li>• Melasma (brown to grey-brown patches on the face)</li> <li>• Rosacea</li> <li>• Vitiligo</li> <li>• Wrinkles; and</li> </ul>	PG0348 Acne Treatments	

<p>Skin rejuvenation and resurfacing/targeted phototherapy using laser therapy to include but not limited to the treatment of rosacea, vitiligo, acne scarring/skin disorders (age spots/brown spots), melasma (brown to gray brown patches on the face), and wrinkles; examples of skin rejuvenation and resurfacing treatment methods include, but are not limited to the following:</p> <ul style="list-style-type: none"> <li>• Laser (Excimer laser) and Intense Light (IPL) Treatments (used to remove discoloration and/or tighten sagging skin)</li> <li>• Chemical peels (various acid peels used in different combinations to remove damaged outer skin layers)</li> <li>• Ablative laser treatments (fractional, CO2 lasers [remove outer layers of skin to smooth lines and wrinkles])</li> <li>• Mechanical ablation (dermabrasion, dermaplaning [surgical scraping methods to soften skin surface irregularities])</li> <li>• Non-ablative treatments (microdermabrasion, microneedling, light acid peels [minimally invasive sanding methods to treat light scarring and discolorations])</li> </ul>	
<p>Lip surgery (i.e. injection of fat, collagen or filler to enlarge or enhance the lips): May be considered medically necessary for neoplasm or trauma</p>	
<p>Liposuction (Lipoplasty) Liposuction is sometimes referred to as “lipo” by patients, it slims and reshapes specific areas of the body by removing excess fat deposits and improving body contours and proportion of the following areas: thighs; hips and buttocks; abdomen and waist; upper arms; back; inner knee; chest area; cheeks, chin and neck; calves and ankles. Liposuction can be performed alone or along with other plastic surgery procedures, such as facelift, breast reduction or a tummy tuck.</p>	
<p>Liposuction – Assisted (Laser/Ultrasound Assisted) Liposuction assisted with laser or ultrasound liquefies the fat before it is removed from the body. Like traditional liposuction, this is not a weight control method or fix for obesity. This is used to help contour the body in those areas that are not responsive to diet and exercise such as saddlebags and paunchy stomach. Also, like traditional liposuction, laser or ultrasound assisted liposuction is most often used to reduce fullness in the following areas: abdomen; ankles; arms; buttocks; cheeks; chin; hips; knees; neck; thighs; upper arms; waist.</p>	
<p>Metabolic and Bariatric Surgery  The use of bariatric surgery with a body mass index less than or equal to 30kg/m<sup>2</sup> is not medically necessary.  Reconstructive surgery (i.e., excision of excessive skin) following obesity surgery (15831–15839) is not a covered benefit.</p>	<p>PG0163 Metabolic and Bariatric Surgery</p>
<p>Mesotherapy (injection of various substances into the tissue beneath the skin to sculpt body contours by lysing subcutaneous fat) Mesotherapy involves the subcutaneous injection of small quantities of substances, such as vitamins, silica, or lecithin, for the purpose of fat or wrinkle reduction. Complementary and alternative medicine treatments are considered investigational and are not covered as a treatment of any condition. Additionally, mesotherapy is consider cosmetic for all indications.</p>	
<p>Neck Tucks A neck lift, or lower rhytidectomy, is a surgical procedure that improves visible signs of aging in the jawline and neck. Rejuvenation procedures that can be performed in conjunction with a neck lift are the following: a brow lift (correct a sagging or deeply furrowed brow); fat transfer (to add</p>	



fullness to the lips and cheeks and reduce the appearance of wrinkles); or eyelid surgery to rejuvenate aging eyes.		
Neurofibromas, destruction, extensive (cutaneous, dermal extending into subcutaneous) <ul style="list-style-type: none"> <li>• Considered cosmetic when there is no interference with normal function.</li> <li>• Considered reconstructive when the following conditions exist that may interfere with normal function such as: <ul style="list-style-type: none"> <li>○ Symptomatic neurofiromas (painful, tender, infected).</li> </ul> </li> </ul>		
Nonsurgical fat reduction (minimally invasive procedures) <p>Nonsurgical or minimally invasive options for fat reduction include technology that uses heat, cooling or an injected medication to reduce fat cells. While none of these treatments are a replacement for liposuction, they provide options for patients unwilling or unable to undergo surgery. Nonsurgical fat reduction options use a variety of modalities, including ultrasound, radiofrequency, infrared light, vacuum massage and injectable medication Among the procedures that comprise nonsurgical fat reduction are:</p> <ul style="list-style-type: none"> <li>• Cryolipolysis (e.g. CoolSculpting)</li> <li>• Injection lipolysis (e.g. Kybella),</li> <li>• Radiofrequency lipolysis (e.g. Vanquish)</li> <li>• Laser lipolysis (e.g. SculpSure)</li> </ul>		
Otoplasty/Pinnaplasty <p>May be considered reconstructive when:</p> <ul style="list-style-type: none"> <li>• Ears are absent; or</li> <li>• Deformed from trauma, surgery, disease or congenital defects</li> <li>• Surgically correctable congenital malformation, trauma, surgery, infection, or other process that is causing hearing loss. [Audiogram must demonstrate a loss of at least 15 decibels in the affected ear(s).</li> </ul> <p>Considered cosmetic when performed to correct large or protruding ears.</p>	PG0376 Otoplasty	
Panniculectomy <p>Considered cosmetic when performed for aesthetic purposes – to solely improve the patient’s appearance in the absence of symptoms or functional abnormalities/impairments.</p>	PG0299 Abdominoplasty, Panniculectomy and Liposuction	
Permanent makeup (i.e. tattoo)		
Phalloplasty (Plastic surgery of the penis or scrotum, generally intended to lengthen or enhance circumference and/or appearance.)		
Platysmal tightening (platysmal flap, P-flap) (facelift)		
Prophylactic mastectomy <p>Prophylactic mastectomy is considered medically necessary and, therefore, covered in individuals who have a high risk or moderately increased risk of developing breast cancer. All other uses for prophylactic mastectomy are considered not medically necessary and, therefore, not covered because the available published peer-reviewed literature does not support their use in the treatment of illness or injury.</p>	PG0251 Prophylactic Mastectomy	
Pulsed-dye laser treatment and excision of port wine stains and other hemangiomas <p>Except when atypical or causing functional limitation (i.e. affects vision, breathing, hearing, ability to eat, bleeding, ulceration, and/or infection.</p>	PG0308 Pulsed Dye Laser Therapy for Cutaneous Vascular Lesions	
Refractive Surgery (Lasik, PRK, PTK) <p>Considered cosmetic when the vision can be adequately corrected using corrective lines or contact lens.</p>	PG0289 Refractive Surgery	
Removal of frown lines (Excision or correction of glabella frown lines)		

<p>Removal of spider angiomata The most common spider vein treatment involves the injection of solution (Asclera, Sotradecol) into the affected vein, causing the vein to collapse and fade over time. Various laser treatments PhotoDerm®, VeinLase™, Vasculite™ and microwave (heat energy) treatments Veinwave and VeinGogh are also available for the reduction or removal of spider veins.</p> <p>Considered cosmetic when indicated for the treatment of spider vein (telangiectasia) using any of the following:</p> <ul style="list-style-type: none"> <li>• Sclerotherapy (Asclera, Sotradecol)</li> <li>• Laser treatments <ul style="list-style-type: none"> <li>○ PhotoDerm</li> <li>○ VeinLase</li> <li>○ Vasculite</li> </ul> </li> <li>• Focused thermal energy <ul style="list-style-type: none"> <li>○ Veinwave</li> <li>○ VeinGogh Thermolysis System</li> </ul> </li> </ul>	<p>PG0091 Treatment of Varicose Veins</p>
<p>Removal of supernumerary nipples (polymastia)</p>	
<p>Rhytidectomy (including meloplasty, face lift) May be considered reconstructive when:</p> <ul style="list-style-type: none"> <li>• For treatment of burns</li> </ul> <p>Considered cosmetic when preformed for treatment of the face for aging skin.</p>	
<p>Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap (facelift) A facelift, or rhytidectomy, is a surgical procedure to improve visible signs of aging in the face and neck. Other procedures that might be performed in conjunction with a facelift are brow lift and eyelid surgery to rejuvenate aging eyes. Fat transfers or fillers may be suggested to replace the lost fatty volume.</p>	
<p>Scar revision: Repair of scars that result from surgery is considered medically necessary if they cause symptoms or functional impairment. Note: Exceptions to cosmetic surgery exclusion may apply to repair of scars that do not cause pain or functional impairment</p>	
<p>Selective neurectomy of the gastrocnemius muscle for correction of calf hypertrophy</p>	
<p>Septoplasty and Rhinoplasty</p> <ul style="list-style-type: none"> <li>• Cosmetic Nasal Surgery When nasal surgery is performed solely to improve the patient's appearance in the absence of any signs and/or symptoms of functional abnormalities, the procedure should be considered cosmetic in nature.</li> <li>• Reconstructive Nasal Surgery When nasal surgery, including rhinoplasty, is performed to improve nasal respiratory function, correct anatomic abnormalities caused by birth defects or disease, or revise structural deformities produced by trauma, the procedure should be considered reconstructive.</li> </ul>	<p>PG0009 Rhinoplasty and Septoplasty</p>
<p>Skin tag removal (Acrochordon) May be considered reconstructive when:</p> <ul style="list-style-type: none"> <li>• Skin tag removal when located in an area of friction with documentation of repeated irritation and bleeding</li> </ul>	<p>PG0105 Benign Skin Lesion Removal</p>
<p>Surgery for body dysmorphic disorder</p>	<p>PG0311 Gender Reassignment Surgery</p>

Refer to Medical Policy PG0311 Gender Reassignment Surgery related to Cosmetic Exceptions.		
Surgery to correct moon face (as a result of corticosteroid therapy)		
Surgery to correct tuberous breast deformity		
Surgical depigmentation (e.g., laser treatment) of nevus of Ito or Ota		
Tattoo removal (laser treatments, chemical peels, dermabrasion and surgical excision) Additionally the tattoo removal process – Salabrasion is noncovered		
Thigh Lift Reshapes the thighs by reducing excess skin and fat, resulting in smoother skin and better-proportioned contours of the thighs and lower body. In cases where skin elasticity is poor, a thigh lift along with liposuction may be recommended.		
Treatment with small gel-particle hyaluronic acid (e.g., Restylane) and large gel-particle hyaluronic acid (e.g., Perlane) to improve the skin's contour and/or reduce depressions due to acne, injury, scars, or wrinkles		
Torn ear lobe repair		
Use of Laviv (azficel-T) Laviv (azficel-T) is an autologous cellular product, treatment with autologous fibroblasts grown in culture (azficel-T), indicated for improvement of the appearance of moderate-to-severe nasolabial fold wrinkles in adults.		
Vaginal rejuvenation procedures (clitoral reduction, designer vaginoplasty, hymenoplasty, re-virgination, G-spot amplification, pubic liposuction or lift, reduction of labia minora, labia majora surgery/reshaping, thermal therapy (e.g., radiofrequency (ThermiVa and Viveve procedures) and laser) and vaginal tightening, not an all-inclusive list)		
Vitiligo treatments (Treatments designed to reestablish skin pigmentation to areas where depigmentation has occurred. Examples include medication, surgery (eg, skin grafting, hair follicle transplantation), the use of ultraviolet light therapy or laser.)	PG0162 Phototherapy, Photochemotherapy, & Excimer Laser for Dermatologic Conditions	
Voice lifting procedures (To restore voice to youthful quality, implants, injections of fat or collagen)		
XEOMIN® (incobotulinumtoxinA) injections when used to improve the appearance of glabellar (frown) lines		
<p>Certain types of procedures require individual consideration to make a determination as to whether the service is cosmetic or reconstructive. Coverage may be dependent upon the cause and functional impairment associated with the condition. As an example, a blepharoplasty may be cosmetic when vision is not impaired, but medically necessary if vision is impaired. As another example, rhinoplasty is generally excluded from coverage when used to improve the shape of one's nose. However, if the nose was broken as a result of trauma and it impacts a person's ability to breathe, the service may be medically necessary. Preauthorization is required for procedures that are potentially cosmetic to allow individual consideration.</p>		

There are diagnoses that indicate services that are performed for cosmetic indications. The services may not usually be defined as cosmetic except when medically supported by the specific cosmetic diagnosis attached to the procedure. These diagnoses, when reported as the primary diagnosis (in the first diagnosis field), will cause the related service to be denied as cosmetic.

Evaluation and management (E/M) services (99201-99215) will not be denied as cosmetic when billed with these diagnoses. Only the actual surgical, radiology, pathology, laboratory, and medicine services provided will be denied when performed for cosmetic indication. The E/M service is a medical necessity for review/determination, and therefore provider reimbursement is warranted.

The following diagnosis codes have been identified to be cosmetic services and will always be denied:

## ICD-10-CM CODES; EFFECTIVE 10/01/2015

<b>Z40.8</b>	Encounter for other prophylactic surgery
<b>Z40.9</b>	Encounter for prophylactic surgery, unspecified
<b>Z41.1</b>	Encounter for cosmetic surgery
<b>Z41.3</b>	Encounter for ear piercing
<b>Z41.8</b>	Encounter for other procedures for purposes other than remedying health state
<b>Z41.9</b>	Encounter for procedure for purposes other than remedying health state, unspecified

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

Paramount 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. The appropriate historical medical record documentation the following:

- Photographs; and/or
- Consultation reports; and/or
- Operative reports and/or other applicable hospital records (examples: pathology report, history and physical); and/or
- Office records; and/or
- Letters with pertinent information from:
  - Providers;
  - Subscribers.

### **HMO, PPO, Individual Marketplace**

Some reconstructive procedures require prior authorization. A provider must refer to the Paramount prior authorization list and specific medical policy in reference to specific procedures

Cosmetic services are non-covered and if performed the member is financially responsible.

### **Advantage**

Some reconstructive procedures require prior authorization. A provider must refer to the Paramount prior authorization list and specific medical policy in reference to specific procedures

For Advantage members, the provider must obtain a waiver of financial liability from the member, per Medicaid guidelines, prior to the performance of a designated reconstructive service that does not require prior authorization. All cosmetic services are non-covered and will be denied as provider's liability regardless of whether the member has signed a written notice or not.

Advantage members may appeal their financial responsibility for the procedure ONLY if:

- The provider failed to obtain the waiver of financial liability prior to performing the procedure. The claim will be adjusted to deny back to the provider.
- There is medical necessity supporting the performance of the service per medical criteria set by Paramount for the service.

For procedures determined to be non-covered, Advantage members must sign a waiver of financial liability. Failure to do so will result in a denial of financial responsibility from the member to the provider.

#### LIPECTOMY (15876, 15877, 15878, 15879)

While there is insufficient evidence in the published medical literature to demonstrate the safety, efficacy and long-term outcomes of lipectomy, The Ohio Department of Medicaid requires this procedure be reviewed for medical necessity. Therefore, it may be covered with a prior authorization for Advantage members.

#### Elite/ProMedica Medicare Plan

Some reconstructive procedures require prior authorization. A provider must refer to the Paramount prior authorization list and specific medical policy in reference to specific procedures

For Elite/ProMedica Medicare Plan members, the provider must obtain a completed ABN from the member, per Medicare guidelines, prior to the performance of the designated cosmetic procedure that does not require a prior authorization.

Elite members may appeal their responsibility for the procedure ONLY if:

- The provider failed to obtain the ABN prior to performing the procedure. The claim will be adjusted to deny back to the provider.
- There is medical necessity supporting the performance of the service per medical criteria set by Paramount for the service.

For procedures determined to be non-covered, Elite members must sign an ABN. Failure to do so will result in a denial of financial responsibility from the member to the provider.

#### CODING/BILLING INFORMATION

The inclusion or exclusion of a code in this section does not necessarily indicate coverage. Codes referenced in this clinical policy are for informational purposes only.

Codes that are covered may have selection criteria that must be met.

Payment for supplies may be included in payment for other services rendered.

CODE	DESCRIPTION	MEDICAL POLICY
0419T	Destruction neurofibroma, extensive, (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibroma	
0420T	Destruction neurofibroma, extensive, (cutaneous, dermal extending into subcutaneous); trunk and extremities, extensive, greater than 100 neurofibroma	
0437T	Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)	
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	PG0105
11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional ten lesions (List separately in addition to code for primary procedure)	PG0105
11920	Intradermal tattooing; 6sq cm or less	PG0144
11921	Intradermal tattooing; 6.1 to 20sq cm	PG0144
11922	Intradermal tattooing; each additional 20sq cm or part thereof	PG0144
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less	PG0348
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0cc	PG0348
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0cc	PG0348
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0cc	PG0348
11970	Replacement of tissue expander with permanent prosthesis	PG0144
11971	Removal of tissue expander(s) without insertion of prosthesis	PG0144



15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascial)	PG0144 And PG0104
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	PG0144
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)	PG0144
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)	
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)	PG0348
15781	Dermabrasion; segmental, face	PG0348
15782	Dermabrasion; regional, other than face	PG0348
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	PG0348
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	PG0348
15789	Chemical peel, facial; dermal	PG0348
15792	Chemical peel, nonfacial; epidermal	PG0348
15793	Chemical peel, nonfacial; dermal	PG0348
15819	Cervicoplasty	
15820	Blepharoplasty, lower lid	PG0007
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	PG0007
15822	Blepharoplasty, upper lid	PG0007
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	PG0007
15824	Rhytidectomy; forehead	
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	
15826	Rhytidectomy; glabellar frown lines	
15828	Rhytidectomy; cheek, chin, neck	
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	PG0299
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	PG0163
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	PG0163
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	PG0163
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	PG0163
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	PG0163
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm/hand	PG0163
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	PG0163
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	PG0163
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)	PG0299
15876	Suction assisted lipectomy; head/neck	
15877	Suction assisted lipectomy; trunk	PG0299
15878	Suction assisted lipectomy; upper extremity	
15879	Suction assisted lipectomy; lower extremity	

17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion	PG0105
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)	PG0105
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions	PG0105
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	PG0308
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	PG0308
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	PG0308
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; up to 14 lesions	PG0105
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; 15 or more lesions	PG0105
17340	Cryotherapy (CO <sub>2</sub> , slush, liquid N <sub>2</sub> ) for acne	PG0348
17360	Chemical exfoliation for acne (e.g., acne paste, acid)	PG0348
17380	Electrolysis epilation, each 30 minutes	
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions [supernumerary nipples]	
19300	Mastectomy for gynecomastia	PG0221
19301	Partial mastectomy (i.e., lumpectomy)	PG0251
19302	Partial mastectomy with lymphadenectomy	PG0251
19303	Simple complete mastectomy	PG0251
19305	Radical mastectomy including pectoral muscles, axillary lymph nodes	PG0251
19306	Radical mastectomy including pectoral muscles, axillary and internal mammary lymph nodes (urban type)	PG0251
19307	Modified radical mastectomy with or without pectoralis minor muscles, axillary lymph nodes but excluding pectoralis major muscle	PG0251
19316	Mastopexy	PG0144
19318	Reduction mammoplasty	PG0054 PG0144
19325	Augmentation mammoplasty with prosthetic implant	PG0054 PG0144
19328	Removal of intact mammary implant	PG0144 PG0012
19330	Removal of mammary implant material	PG0144 PG0012
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	PG0144 PG0012
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction	PG0144 PG0012
19350	Nipple/areole reconstruction	PG0144
19355	Correction of inverted nipples	PG0144
19357	Breast reconstruction (immediate or delayed) with tissue expander, including subsequent expansion	PG0144
19361	Breast reconstruction with latissimus dorsi flap without prosthetic implant	PG0144
19364	Breast reconstruction with free flap	PG0144
19367	Breast reconstruction with transverse rectus abdominis myocutaneous (tram), single pedicle, including closure of the donor site	PG0144

19368	Breast reconstruction with transverse rectus abdominis myocutaneous (tram), single pedicle with microvascular anastomosis (supercharging)	PG0144
19369	Breast reconstruction with transverse rectus abdominis myocutaneous (tram), double pedicle, including closure of the donor site	PG0144
19370	Open periprosthetic capsulotomy, breast	PG0144 PG0012
19371	Periprosthetic breast capsulectomy	PG0144 PG0012
19380	Revision of reconstructed of breast	PG0144
19396	Preparation of moulage for custom breast implant	PG0144
21120	Genioplasty; augmentation	PG0056 PG0226
21121	Genioplasty; sliding osteotomy	PG0056 PG0226
21122	Genioplasty; sliding osteotomies	PG0056 PG0226
21123	Genioplasty; sliding augmentation	PG0056 PG0226
21125	Augmentation, mandibular body or angle; prosthetic material	PG0226
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	PG0226
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	
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft	PG0056 PG0226
21142	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, without bone graft	PG0056 PG0226
21143	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, without bone graft	PG0056 PG0226
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	PG0056 PG0226
21146	Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)	PG0056 PG0226
21147	Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)	PG0056 PG0226
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)	PG0226
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	PG0226
21154	Reconstruction midface, LeFort III; (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	PG0226
21155	Reconstruction midface, LeFort III; (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I	PG0226
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I	PG0226
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	PG0226
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 (eg, 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	PG0226
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	PG0226
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	PG0226
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	PG0226
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	PG0226
21193	Reconstruction of mandible rami; horizontal, vertical, C, or L osteotomy; without bone graft	PG0056 PG0226
21194	Reconstruction of mandible rami; horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	PG0056 PG0226
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	PG0056 PG0226
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	PG0056 PG0226
21198	Osteotomy, mandible, segmental	PG0056 PG0226
21199	Osteotomy mandible; w/ advancement	PG0056 PG0226
21206	Osteotomy, maxilla, segmental (e.g., Wassmund or Schuchard)	PG0226
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	PG0226
21209	Osteoplasty, facial bones; reduction	PG0226
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	PG0226
21215	Graft, bone; mandible (includes obtaining graft)	PG0226
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	PG0226
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	PG0226
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	PG0226
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	PG0226
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	PG0226
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	PG0226
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia)	PG0226
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	PG0226
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	PG0226
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)	PG0226
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, 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	
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach	
21270	Malar augmentation, prosthetic material	PG0226
21275	Secondary revision of orbitocraniofacial reconstruction	PG0226
21280	Medial canthopexy (separate procedure)	
21282	Lateral canthopexy	
21295	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach	PG0226
21296	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach	PG0226
21740-21743	Reconstructive repair of pectus excavatum or carinatum	PG0144
30120	Excision or surgical planning of skin of nose for rhinophyma	
30124	Excision dermoid cyst, nose; simple, skin, subcutaneous	
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	PG0009
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	PG0009
30420	Rhinoplasty, primary; including major septal repair	PG0009
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	PG0009
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	PG0009
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	PG0009
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	PG0009
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies	PG0009
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)	PG0009
36468	Injection(s) of sclerosant for spider veins (telangiectasis), limb or trunk	PG0091
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	PG0163
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	PG0163
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)	PG0163
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	PG0163
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	PG0163
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	PG0163
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	PG0163
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)	PG0163
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical banded gastroplasty	PG0163
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical banded gastroplasty	PG0163
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	PG0163



43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150cm or less) Roux-en-Y gastroenterostomy	PG0163
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	PG0163
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	PG0163
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	PG0163
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	PG0163
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	PG0163
49250	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)	
54400	Insertion of penile prosthesis; noninflatable (semi-rigid)	PG0256
54401	Insertion of penile prosthesis; inflatable (self-contained)	PG0256
54405	Insertion of multi-component inflatable penile prosthesis, including placement of pump, cylinders and reservoir	PG0256
54410	Removal and replacement of all components of a multicomponent penile prosthesis at the same operative session	PG0256
54411	Removal and replacement of all components of a multicomponent penile prosthesis at the same operative session, including irrigation/debridement of infected tissue	PG0256
54416	Removal and replacement of non-inflatable or inflatable penile prosthesis at the same operative session	PG0256
54417	Removal and replacement of non-inflatable or inflatable penile prosthesis at the same operative session, including irrigation/debridement of infected tissue	PG0256
54660	Insertion of testicular prosthesis	PG0311
55970	Intersex surgery; male to female	PG0311
55980	Intersex surgery; female to male	PG0311
56800	Plastic repair of introitus	PG0311
65760	Keratomileusis	PG0289
65765	Keratophakia	PG0289
65767	Epikeratoplasty	PG0289
65771	Radial keratotomy (RK)	PG0289
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	PG0007
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	PG0007
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	PG0007
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	PG0007
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	PG0007
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	PG0007
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)	PG0007
67909	Reduction of overcorrection of ptosis	PG0007
67911	Correction of lid retraction	PG0007
69090	Ear piercing	
69300	Otoplasty, protruding ear, with or without size reduction	PG0376
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm	PG0162
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm	PG0162
96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm	PG0162
G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (Lds) (e.g., as a result of highly active antiretroviral therapy)	
L8600	Implantable breast prosthesis, silicone or equal	PG0144
L8603	Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies	PG0497

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	
S0800	Laser in-situ keratomileusis (Lasik)	PG0289
S0810	Photorefractive keratectomy (PRK)	PG0289
S0812	Phototherapeutic keratectomy (PTK)	PG0289
S2066	Breast reconstruction with gluteal artery perforator (gap) flap, inc harvesting of flap, microvascular transfer, closure of donor site/shaping the flap into breast, unilateral	PG0144
S2067	Breast reconstruction of a single breast with "stacked" deep inferior epigastric perforator (DIEP) flap(s) and/or gluteal artery perforator (gap) flap(s), inc harvesting of flap(s), microvascular transfer, closure of donor site(s)/shaping flap into breast, unilateral	PG0144
S2068	Breast reconstruction with deep inferior epigastric perforator (DIEP) flap or superficial inferior epigastric artery (SIEA) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral	PG0144
S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline	PG0163
<p>Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to <a href="https://www.paramounthealthcare.com/services/providers/medical-policies/">https://www.paramounthealthcare.com/services/providers/medical-policies/</a> .</p>		

## REVISION HISTORY EXPLANATION

**ORIGINAL EFFECTIVE DATE: 04/15/2008**

Date	Explanation & Changes
01/28/11	<ul style="list-style-type: none"> <li>E/M services 99201-99215 will be reimbursed when submitted with specific codes that are considered cosmetic per medical policy review</li> </ul>
07/22/11	<ul style="list-style-type: none"> <li>Per the Medical Policy Steering Committee review and determination, diagnosis code 701.4 – keloid scar, will be removed from the listed cosmetic diagnosis services. All product lines</li> </ul>
09/08/15	<ul style="list-style-type: none"> <li>Changed title from Cosmetic Services to Cosmetic and Reconstructive Surgery</li> <li>Removed ICD-9 codes V51.8, 302.50, 302.51, 302.52, 302.53, 701.4, 18.01, 64.5, 86.24, and 86.25</li> <li>Added ICD-9 codes 309.1 and V50.8. ICD-10 codes added from ICD-9 conversion</li> <li>CPT codes 40819, 41115, 56620, 65710, 69300, 68310, 69320 removed from this policy</li> <li>Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee</li> </ul>
08/09/16	<ul style="list-style-type: none"> <li>Added L8607 as non-covered for all product lines</li> <li>Added code 69300 and reference to new medical policy PG0376 Otoplasty</li> <li>Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee</li> </ul>
01/10/17	<ul style="list-style-type: none"> <li>Effective 01/01/17 codes 15876, 15878, 15879 are now covered with prior authorization for Advantage only per ODM guidelines</li> <li>Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee</li> </ul>
05/31/19	<ul style="list-style-type: none"> <li>Removed diagnosis code F43.21. Diagnosis code F43.21 was inappropriately included.</li> </ul>
12/14/2020	<ul style="list-style-type: none"> <li>Medical policy placed on the new Paramount Medical policy format</li> </ul>
11/01/2021	<ul style="list-style-type: none"> <li>Removed procedure 65770, keratoprosthesis is never considered/indicated as cosmetic</li> <li>Removed procedure code sets 11300-11313 and 11400-11446, PG0105, reference from the CODING/BILLING INFORMATION, is not relevant to PG0104</li> <li>Removed the following deleted codes 15831, 19304, 19324, 19366, C9800</li> <li>Added the following codes 0419T, 0420T, 0437T, 15769, 15771, 15772, 15773, 15774, 19120, 30124, 49250, 56800, L8603 related to cosmetic and reconstructive surgery reference</li> </ul>

	<ul style="list-style-type: none"> <li>Effective December 1st, 2021 procedures 15773 and 15774 will require a prior authorization for the Advantage Product line</li> </ul>
<b>12/22/2021</b>	<ul style="list-style-type: none"> <li>Corrected a documentation error, procedure 15830- <i>Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy</i>, is addressed in medical policy PG0299 Abdominoplasty, Panniculectomy and Liposuction requiring a prior authorization for all product lines. This prior authorization is to be maintained.</li> </ul>
<b>12/23/2021</b>	<ul style="list-style-type: none"> <li>Add documentations indicating when procedures 15773 and 15774 support coverage for the Advantage product</li> </ul>

## REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Ohio Department of Medicaid

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

U.S. Preventive Services Task Force, <http://www.uspreventiveservicestaskforce.org/>  
Industry Standard Review

Hayes, Inc.

Industry Standard Review