LifeWise

Health Plan of Washington

MEDICAL POLICY – 10.01.514

Cosmetic and Reconstructive Services

Effective Date:	Dec. 1, 2024	RELATED MEDICAL POLICIES:	
Last Revised	Jan. 1, 2025	1.01.506	Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses
Replaces:	N/A	2.01.71	Nonpharmacologic Treatment of Rosacea
		5.01.512	Botulinum Toxin
		5.01.530	Egrifta SV
		7.01.153	Adipose-Derived Stem Cells in Autologous Fat Grafting to the Breast
		7.01.508	Blepharoplasty, Blepharoptosis and Brow Ptosis Surgery
		7.01.519	Treatment of Varicose Veins/Venous Insufficiency
		7.01.521	Mastectomy for Gynecomastia
		7.01.523	Panniculectomy and Excision of Redundant Skin
		7.01.533	Reconstructive Breast Surgery/Management of Breast Implants
		7.01.557	Gender Transition/Affirmation Surgery
		7.01.558	Rhinoplasty
		9.02.500	Orthodontic Services for Treatment of Congenital Craniofacial Anomalies
		9.02.501	Orthognathic Surgery
		10.01.517	Non-covered Services and Procedures

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Introduction

There are generally two types of plastic surgery, cosmetic and reconstructive. Cosmetic surgery is performed to improve appearance, not to improve function or ability. The plan does not cover cosmetic surgery. Reconstructive surgery focuses on reconstructing defects of the body or face due to trauma, burns, disease, or birth disorders. Reconstructive surgery is designed to restore or improve function associated with the presence of a defect. This policy outlines when reconstructive surgery may be covered.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for

providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Procedure	Reconstructive/Medical Necessity

Reconstructive services	**Reconstructive surgery is performed on abnormal structures of the body, caused by congenital (occurring at birth) defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve or restore bodily function when there is an objective physical functional impairment present.**
	
	The following procedures may be considered reconstructive and therefore, medically necessary when the following functional impairment criteria are met:
	• Chin surgery (genioplasty or mentoplasty) may be considered medically necessary for the repair of maxilla or mandible resulting from trauma, injury, or disease (see below for **cosmetic**)
	• Dermabrasion for removal of superficial basal cell carcinomas or actinic keratoses is considered medically necessary (see below for **cosmetic**)
	• Labiaplasty may be considered medically necessary for the following conditions (see below for **cosmetic**):
	  ○ Chronic irritation (pain from friction during physical or sexual activity) that has persisted for 12 weeks in spite of conservative management (such as wearing loose fitting underwear and clothing, use of topical ointments or emollients, use of protective padding for physical activities such as cycling or horseback riding, and following good hygiene practices)
	  ○ Correction of atypical genitalia (previously termed ambiguous genitalia)

Procedure	Reconstructive/Medical Necessity
	◦ Repair of congenital asymmetrical labial growth (childhood asymmetry labium majus enlargement [CALME]) in the presence of a functional impairment ◦ Repair of congenital defect (e.g., as a result of congenital adrenal hyperplasia) • Otoplasty/Pinnaplasty may be considered medically necessary when the ears are absent or deformed from congenital defect (e.g., aural atresia, microtia, anotia) trauma, or disease and performed to improve hearing by directing sound in the ear canal (see below for **cosmetic**) ◦ Use of a nonsurgical infant ear molding (e.g., EarWell) may be considered medically necessary to correct congenital auricular anomalies in infants 3 months of age or less. • Rhytidectomy (face lift) may be considered medically necessary for the treatment of severe burns to the face (see below for **cosmetic**) • Scar revision may be considered medically necessary when the revision corrects an objective functional impairment, and the following criteria are met (see below for **cosmetic**): ◦ Scar(s) causes symptoms or functional impairment (e.g., pain, contracture(s), skin tension, restricts movement of a joint) **AND** ◦ The scar resulted from an accidental injury, trauma, burn, or a medically necessary surgical procedure • Skin tag removal may be considered medically necessary when located in an area of friction causing repeated irritation and bleeding (see below for **cosmetic**) • Tattoo may be considered medically necessary as part of breast reconstructive surgery post-mastectomy (see below for **cosmetic**) **The following procedures may be considered reconstructive and therefore, medically necessary when functional impairment criteria are met as described in the specific Related Policies:** • Blepharoplasty

Procedure	Reconstructive/Medical Necessity
	• Breast reduction • Gynecomastia surgery • Orthognathic surgery • Panniculectomy • Rhinoplasty
Breast cancer	**The Women's Health and Cancer Rights Act of 1998 requires that in individuals with breast cancer or a history of breast cancer, all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce symmetrical appearance, prostheses and treatment of physical complications of the mastectomy including lymphedema are considered medically necessary (see Related Policies).**
Prosthetic devices	**The following prosthetic devices that replace all or part of an external body part that are lost or impaired as a result of disease, injury, or congenital defect including any of the following are considered medically necessary:** • Ear (auricular) prostheses • Eye (ocular) prostheses • Testicular prostheses

Procedure	Cosmetic
Cosmetic services	**Cosmetic surgery is performed to reshape normal structures of the body in order to improve the individual's appearance or self-esteem.** **The following procedures or pharmaceutical agents may be considered cosmetic when the primary purpose is to preserve or improve appearance in the absence of a physical functional impairment (defined below):** **Procedures** • Abdominoplasty (tummy tuck) • Arm lift (brachioplasty) • Breast augmentation (breast implants) • Breast lift (mastopexy)

Procedure	Cosmetic
	• Buttock or thigh lift • Canthopexy or canthoplasty (correction of sagging lower eyelids) • Chin implant/reduction (genioplasty or mentoplasty) in the absence of a functional impairment (see above for **reconstructive**) • Dermabrasion for removal of acne scars, treatment of acne vulgaris, wrinkling, aging skin, or pigmentation (e.g., freckles, age spots) (see above for **reconstructive**) • Diastasis recti repair • Excessive/redundant skin removal from limbs and other areas of the body • Facial bone reduction or enhancement • Facial rejuvenation/plumping/collagen or fat grafts/injections • Injectable dermal fillers used to sculpt body contours • Inverted nipple correction • Labial reduction (labiaplasty)/surgical reduction of the labia minora to enhance appearance or sexual performance is considered cosmetic (see above for **reconstructive**) • Laser skin resurfacing for wrinkling, aging skin, or spider angiomas • Lip augmentation • Liposuction used for body contouring for alteration of appearance • Lipectomy (includes belt lipectomy, circumferential lipectomy and others) • Lower body lift • Neck tuck/lift (cervicoplasty) • Penis enhancement surgery • Otoplasty for large or protruding ears to improve physical appearance (see above for **reconstructive)** • Removal of glabellar frown lines • Rhytidectomy (face lift) for aging skin (see above for **reconstructive**) • Scar revision to improve appearance in the absence of a functional impairment (see above for **reconstructive**)

Procedure	Cosmetic
	• Skin tag removal to improve appearance in the absence of a functional impairment (see above for **reconstructive**) • Tattoo (see above for **reconstructive**) • Tattoo removal (salabrasion) • Torsoplasty (body lift) • Treatment for skin wrinkles • Treatment for spider veins (telangiectasia) • Vaginal rejuvenation procedures (e.g., clitoral reduction, hymenoplasty, G-spot amplification, pubic liposuction or lift, vaginal tightening) **Note:** Certain procedures listed above may be related to gender transition/affirmation surgery and considered medically necessary when criteria are met. Please see **Related Policies**. **Pharmaceutical Agents (list may not be all inclusive)** • Botox Cosmetic (onabotulinum toxin for cosmetic use) • Bellafill (polymethylmethacrylate [pmma]) microspheres • Belotero (non-animal hyaluronic acid [NaHA]) gel • Daxxify (daxibotulinumtoxinA-lanm) when used for the treatment of wrinkles (glabellar lines) • Egrifta SV (tesamorelin) • Jeuveau (prabotulinumtoxin A-xvfs) • Juvederm (hyaluronic acid) gel • Kybella (deoxycholic acid) injection • Letybo (letibotulinumtoxinA-wlbg) • Latisse (bimatoprost) • LaViv (azficel-T) • Mirvaso (brimonidine topical gel) • Olumiant (baricitinib)* for the treatment of alopecia areata • Opzelura (ruxolitinib) cream for the treatment of nonsegmental vitiligo • Radiesse (calcium hydoxylapatite particle in an aqueous gel carrier) • Restylane (hyaluronic acid) gel • Revanesse (hyaluronic acid) gel • Rha Redensity (resilient hyaluronic acid) • Sculptra Aesthetic (injectable poly-L-lactic acid)

Procedure	Cosmetic
	• Rhofade (oxymetazoline hydrochloride) topical cream • Vaniqa (eflornithine) (topical cream) • Xeomin (incobotulinumtoxinA) when used for facial lines • Zyderm (injectable collagen) • Zyplast (injectable collagen) • Any topical agent not containing a US Food and Drug Administration (FDA)-approved legend drug whose primary purpose is other than to preserve or improve appearance in the absence of a physical functional impairment ***Note:** Drugs for alopecia are excluded under many benefit plans. Therefore, the use of Olumiant (baricitinib) for alopecia areata may not be covered. Please refer to the applicable benefit plan document to determine benefit availability.

Coding

Code	Description
CPT	
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 sq cm to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
11950	Subcutaneous injection of filling material (e.g., collagen); 1cc 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
11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander(s) without insertion of implant

Code	Description
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)
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 four lesions or less (List separately in addition to code for primary procedure)
15819	Cervicoplasty (code termed effective 1/01/2025)
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platsymal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoapneurotic system (SMAS) flap
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand

Code	Description
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision excessive skin and subcutaneous tissue (includes lipectomy); other areas
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm
17107	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq cm
17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq cm
19316	Mastopexy
19325	Mammaplasty, augmentation; with prosthetic implant
19328	Removal of intact breast implant
19330	Removal of ruptured breast implant, including implant contents (e.g., saline, silicone gel)
19340	Insertion of breast implant on same day of, mastectomy (i.e., immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
21088	Impression and custom preparation; facial prosthesis
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece

Code	Description
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
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
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
36468	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk
54660	Insertion of testicular prosthesis (separate procedure)
56620	Vulvectomy simple; partial
67950	Canthoplasty (reconstruction of canthus)
69300	Otoplasty, protruding ear, with or without size reduction
69399	Unlisted procedure, external ear (used to report EarWell Infant Ear Correction System)
HCPCS	
C9160	Injection, daxibotulinumtoxina-lanm (Daxxy), 1 unit (new code effective 1/1/2024)
E1399	Durable medical equipment, miscellaneous (used to report EarWell Infant Ear Correction System)
J0585	Injection, onabotulinumtoxinA, (Botox) 1 unit
J0586	Injection, abobotulinumtoxinA, (Dysport) 5 units
J0587	Injection, rimabotulinumtoxinB, (Myobloc) 100 units
J0588	Injection, incobotulinumtoxinA, (Xeomin) 1 unit
J0591	Injection, deoxycholic acid, (Kybella)1 mg

Code	Description
J3490	Unclassified drugs (Use to report pharmaceuticals that have no specific code)
J3590	Unclassified biologics (Use to report pharmaceuticals that have no specific code)
Q2026	Injection, Radiesse, 0.1 ml
Q2028	Injection, Sculptra, 0.5 mg

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Related Information

Definition of Terms

When specific definitions are not present in a member's plan, the following definitions will be applied.

Congenital anomaly: A marked difference from the normal structures of an infant's body part, that's present from birth and manifests during infancy.

Cosmetic: In this policy, cosmetic services are those which are primarily intended to preserve or improve appearance. Cosmetic surgery is performed to reshape normal structures of the body in order to improve the individual's appearance or self-esteem.

Physical functional impairment: In this policy, physical functional impairment means either limitation from normal physical functioning or baseline level of functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body part(s) or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairments or potential impairments.

Reconstructive surgery: In this policy, reconstructive surgery refers to surgeries performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function.

Determination of Eligibility for Coverage

The final determination of eligibility for coverage should be based on application of the specific contract language based on the etiology of the defect and the presence or absence of documented **physical functional impairment**.

Administering the Contract Language (also see Benefit Application)

The following general principles describe the issues to be determined in properly administering the contract language.

1. The eligibility of a service for coverage may be based on either a specific benefit addressing cosmetic or reconstructive services or on its specific exemption or exclusion for cosmetic or reconstructive services or both.
2. Cosmetic services are usually considered to be those that are primarily to restore appearance and that otherwise do not meet the definition of reconstructive. The definition of reconstructive may be based on two distinct factors:
    - Whether the service is primarily indicated to improve or correct a functional impairment or is primarily to improve appearance; and
    - The etiology of the defect (e.g., congenital anomaly, anatomic variant, result of trauma, post-therapeutic intervention, disease process).
3. The presence or absence of a functional impairment is a critical point in interpreting coverage eligibility. For musculoskeletal conditions, the concept of a functional impairment is straightforward. However, when considering dermatologic conditions, the function of the skin is more difficult to define. Procedures designed to enhance the appearance of the skin are typically considered cosmetic.

Benefit Application

Benefit determinations are based on the applicable contract language in effect at the time the service was rendered or requested. Exclusions, limitations, or exceptions may apply. Benefits may vary based on the contract, and individual member benefits must be verified.

Most plans do not cover services, drugs or supplies for cosmetic purposes, including any direct or indirect complications and aftereffects. Examples of what is not covered are reshaping normal structures of the body in order to improve or change your appearance and self-esteem and not primarily to restore an impaired function of the body.

Considerations when reviewing a case: Contract language may vary regarding the definition of reconstructive services for different categories of conditions. Two key considerations are listed below:

- First, it must be determined whether a functional impairment is present that would render its treatment medically necessary and thus eligible for coverage if no other exclusions apply.
- Second, if no functional impairment is present, the etiology of the condition must be determined, and the contract language reviewed to see if this etiology is included in the definition of reconstructive services.

Consensus Review

Description

The coverage of medical and surgical therapies to treat musculoskeletal abnormalities and abnormalities of the integumentary system are often based on a determination of whether the abnormality is considered reconstructive or cosmetic in nature.

While reconstructive is often taken to mean that the service "returns the patient to whole" and cosmetic is often interpreted as meaning the restoration of appearance only, the application of these terms must be based on specific contract language that may vary from those in the **Definition of Terms** section.

Background

Cosmetic Genital Procedures

Vaginal procedures referred to as "rejuvenation" surgery are generally considered cosmetic as most are performed for aesthetic reasons to enhance appearance. Labia reduction surgery, also known as labiaplasty, removes excess skin or reshapes the labia, or vaginal lips. The labia minora

are part of the external structure of the vagina. In some individuals the labia minora may be enlarged or asymmetrical leading to mild discomfort with wearing certain clothing or during some activities. Reconstructive surgical procedures have been proposed to reduce enlarged labia minora. These procedures have not been well studied in the medical literature. (See **Related Policies** for procedures that are under gender transition/affirmation surgery.)

Practice Guidelines and Position Statements

American College of Obstetricians and Gynecologists (ACOG)

The American College of Obstetricians and Gynecologists (ACOG) Committee Opinion (2007; reaffirmed in 2019)[5] states "…other procedures, including vaginal rejuvenation, designer vaginoplasty, revirgination, and G-spot amplification are not medically indicated, and the safety and effectiveness of these procedures have not been documented." The opinion goes on to state… "no adequate studies have been published assessing the long-term satisfaction, safety, and complication rates for these procedures."

Labial Surgery in Adolescents

The American College of Obstetricians and Gynecologists (ACOG) Committee Opinion (2017; reaffirmed in 2019) on Breast and Labial Surgery in Adolescents made the following recommendation: "Surgical correction (labiaplasty) in girls younger than 18 years should be considered only in those with significant congenital malformation, or persistent symptoms that the physician believes are caused directly by labial anatomy, or both. Physicians should be aware that surgical alteration of the labia that is not necessary to the health of the adolescent, who is younger than 18 years, is a violation of federal criminal law. At least half of the states also have laws criminalizing labiaplasty under certain circumstances, and some of these laws apply to minors and adults. Obstetrician–gynecologists should be aware of federal and state laws that affect this and similar procedures."

Regulatory Status

Injectable Dermal Fillers

The FDA has approved a number of injectable dermal fillers and volume-producing agents for treatment localized to the face in order to create a smoother appearance. These include, but are not limited to the following:

- Calcium hydroxylapatite microsphere (Radiesse)
- Hyaluronic acid (Restylane, Perlane, Elevess, Prevelle Silk, Teosyal, Revanesse Ultra)
- Poly-L-lactic acid (Sculptra)

The FDA published a safety communication in 2018 which states "To alert individuals and health care providers that the use of energy-based devices to perform vaginal 'rejuvenation,' cosmetic vaginal procedures, or non-surgical vaginal procedures to treat symptoms related to menopause, urinary incontinence, or sexual function may be associated with serious adverse events. The safety and effectiveness of energy-based devices for treatment of these conditions has not been established."

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History

Date	Comments
09/13/11	New Policy – Add to Administrative section.
02/14/12	Replace Policy – Policy updated with an additional policy statement indicating collagen skin testing as medically necessary when the primary procedure meets medically necessary criteria. HCPCS code Q3031 was added to the policy.
04/16/12	Related Policies updated: 7.01.09 removed, as this policy has been archived.
07/20/12	Related Polices updated: the title of 2.01.47 changed as of July 10, 2012.
01/29/13	Replace policy. No changes.
06/03/13	Coding update. CPT code 15777 added to the policy.
06/04/13	Update Related Policies. Change title to 7.01.508.
09/30/13	Update Related Policies. Add 9.02.500.

Date	Comments
02/24/14	Replace policy. HCPCS code Q2026 and Q2028; are considered cosmetic. Policy statement clarified – Injectable replaced with injectable dermal fillers. Added reference 3. CPT codes 15775 – 15776 are on the non-covered list and have been removed from the policy; 15777 is an add-on code and has also been removed; 15820-15823, 19300 and 19318 have been removed as they apply to and are included in specific policies.
04/18/14	Update Related Policies. Add 9.02.501.
10/13/14	Interim update. Adding blanket statement indicating that when coverage criteria are not met, services are considered cosmetic. Update coding table to delineate non-covered, cosmetic and medically necessary services.
12/01/14	Update Related Policies. Change title 7.01.508.
12/17/14	Coding update. CPT codes 21230 and 21235 added to the policy.
01/13/15	Minor update. Removed Rhinoplasty and Septoplasty from policy statement and CPT codes 30400-30465; these are surgeries addressed in policy 7.01.558. Added 7.01.558 to Related Policies section; 2.01.514 removed from same section; it has been archived. Pharmacy update: cosmetic indications added for pharmaceutical agents which are considered cosmetic.
03/13/15	Coding update. CPT code 69300 adding to the list of codes considered cosmetic.
05/12/15	Annual Review. Policy reviewed. The following procedures added to the policy cosmetic procedures list: abdominoplasty (includes mini or modified abdominoplasty), brachioplasty, diastasis recti surgery, labiaplasty, lipectomy (includes belt & circumferential lipectomy), lower body lift, tattoo removal, thigh lift, torosoplasty. Kybella added to the list of cosmetic pharmaceuticals. Policy 7.01.523 Title updated in Related Policies section. Definition of Terms moved to Policy Guidelines from the Benefit Application section. Cosmetic genital procedures added to Description section. Reference 1 updated from 2010 ASPS Statistics report to the 2013 Plastic Surgery Statistics Report. References 1, 5, 6 added. CPT 15847 moved from Medically Necessary to Cosmetic codes list. CPT 56620 added to cosmetic codes list. Policy statement changed as noted.
02/09/16	Annual Review. Policy reviewed; no change to the policy statement.
03/01/17	Annual Review, approved February 14, 2017. No change to policy statement. Updated Related Policies section. In History, updated and corrected links for references 1 and 2.
03/30/17	Minor formatting update.
06/01/17	Interim Review, approved May 16, 2017. Added a pharmaceutical product called Rhofade to the cosmetic category. Coding update, removed CPT codes 15788, 15789, 15792, and 15793 as they do not relate to this policy.
11/01/17	Interim Review, approved October 3, 2017. Penis enhancement surgery added to the list of procedures considered cosmetic when medical necessity criteria are not met; code 54360 added to the cosmetic codes section in association with this update. Added “Cosmetic / Reconstructive” coding section to policy.

Date	Comments
07/01/18	Annual Review, approved June 22, 2018. Chin implants, neck tucks, and removal of frown lines added to list of procedures considered cosmetic when medical necessity criteria are not met to align with CPT codes reviewed. Minor edits in nomenclature for clarity.
04/01/19	Annual Review, approved March 19, 2019. Reference 7 added. References updated. Minor edits to policy statements for clarity; otherwise policy statements unchanged.
10/01/19	Coding update, removed CPT code 54360.
01/03/20	Coding update, removed CPT code 11960.
01/10/20	Coding update added CPT codes 15771, 15772, 15773, and 15774 (new codes effective 1/1/20). Removed CPT code 40500.
02/01/20	Annual Review, approved January 14, 2020. Policy reorganized for greater clarity. References added. Added medical necessity criteria for chin implants, labiaplasty, otoplasty, and rhytidectomy. Canthopexy/canthoplasty, facial bone reduction or enhancement, laser skin resurfacing, lip augmentation, liposuction for body contouring for alteration of appearance and vaginal rejuvenation procedures added to list of cosmetic procedures. Added CPT 67950. Removed CPT codes 17106, 17107, 17108, 65760, 65765, and 65767. Electrolysis (17380) and ear piercing (69090) removed from this policy as not applicable.
09/01/20	Interim Review, approved August 20, 2020. Added laser skin treatment for spider angiomas is considered cosmetic. Added CPT codes 17106 and 36468.
12/01/20	Coding update, added note that CPT codes 19324 and 19366 are terminated 1/1/21.
06/01/21	Annual Review, approved May 4, 2021. Policy reviewed. References updated. Policy statement unchanged.
03/01/22	Annual Review, approved February 7, 2022. Policy reviewed. References updated. Minor edit for clarity; otherwise policy statements unchanged. Removed Juvederm from policy; it is no longer on the market.
09/01/22	Interim Review, approved August 22, 2022. Updated list of pharmaceutical agents used for cosmetic purposes. Added HCPCS codes J0585, J0586, J0587, J0588, J0591, J3490 and J3590. Removed CPT codes 19324 and 19366. Updated Related Policies section.
10/01/22	Interim Review, approved September 26, 2022. Added dermabrasion for removal of superficial basal cell carcinomas or actinic keratoses is considered medically necessary and clarified dermabrasion is considered cosmetic for removal of acne scars, treatment of acne vulgaris, wrinkling, aging skin, or pigmentation (e.g., freckles, age spots). Added the following prosthetic devices that replace all or part of an external body part that are lost or impaired as a result of disease, injury, or congenital defect including any of the following are considered medically necessary: ear, eye, testicular prostheses. Added CPT code 54660. Changed the wording from "patient" to "individual" throughout the policy for standardization.
03/01/23	Coding update. Added CPT codes 17107 and 17108.

Date	Comments
05/01/23	Interim Review, approved April 11, 2023. Added Daxxify, Olumiant, and Opzelura to the list of pharmaceutical agents that are considered cosmetic.
06/15/23	Minor update to Related Policies. 1.01.11 is replaced by 1.01.506 Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses.
11/01/23	Annual Review, approved October 23, 2023. Policy reviewed. Reference added. Minor edits made for clarity; policy intent unchanged. Added policy 2.01.71 Nonpharmacologic Treatment of Rosacea to Related Policies section.
12/01/23	Interim Review, approved November 14, 2023. References added. Adding a policy statement that use of a nonsurgical infant ear molding (e.g., EarWell) may be considered medically necessary to correct congenital auricular anomalies in infants 3 months of age or less. Clarified that correction of inverted nipples is considered cosmetic. The CPT code 19355 has been pending on the policy, but the policy statement was absent, policy intent unchanged. Added CPT code 69399 and HCPCS code E1399 for EarWell Infant Ear Correction System.
04/01/24	Coding update. Added CPT C9160.
05/01/24	Interim Review, approved April 9, 2024. Added Letybo to list of pharmaceutical agents considered cosmetic and clarified that Daxxify when used for the treatment of wrinkles is considered cosmetic.
11/01/24	Annual Review, approved October 21, 2024. Policy reviewed. No references added. Policy statements unchanged.
12/01/24	Interim Review, approved November 25, 2024. Xeomin added to list of pharmaceutical agents considered cosmetic. Other minor edits made for clarity only.
01/01/25	Coding update. Termed CPT code 15819.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2025 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.