MN.006.J Cosmetic & Reconstructive Services

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Thank you for being a valued provider for members in one or more of our health plans: Jefferson Health Plans Medicare Advantage, Jefferson Health Plans Individual and Family Plans, Jefferson Health Plans CHIP, and/or Jefferson Health Plans EverWell (our Medicaid plan).

**** NOTIFICATION OF PENDING POLICY IMPLEMENTATION *****

Please note that this Policy Bulletin will be implemented on 12/07/2026. This document provides a 30-day notification of its pending implementation and is not currently implemented.

PRODUCT VARIATIONS

This policy applies to all Jefferson Health Plans lines of business unless noted below.

Medicare Variation

For details regarding Medicare's exclusion of cosmetic procedures, refer to the Medicare Benefit Manual (Pub.100-2), Chapter 16, § 120 - Cosmetic Surgery. For additional details, see Policy Guidelines.

Related Medicare National Coverage Determinations (NCD) Manual (Pub 100-03)

- NCD 140.2 Breast Reconstruction Following Mastectomy
- NCD 250.5 Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS)
- NCD 140.4 Plastic Surgery to Correct "Moon Face"
- NCD 250.4 Treatment of Actinic Keratosis

Related Local Coverage Determination

- L35090 Cosmetic and Reconstructive Surgery

- L34938 Removal of Benign or Premalignant Skin Lesions
- L35004 Surgery: Blepharoplasty
- L34924-Treatment of Chronic Venous Insufficiency of the Lower Extremities

POLICY STATEMENT

We utilize the InterQual Procedures medical necessity criteria to determine the medical necessity of procedures addressed within the module. Where InterQual does not address a service, this policy applies.

DIFFERENTIATING COSMETIC AND RECONSTRUCTIVE

A procedure is considered reconstructive and medically necessary if **BOTH** of the following apply:

1. Medical records show that physical/physiological abnormality is causing functional impairment that requires correction. *(Functional impairment is defined below*.

2. The proposed treatment is proven safe and effective and is likely to improve or restore the patient's function.

A procedure is considered cosmetic and excluded from coverage if the condition is NOT associated with functional impairment and/or treatment does not correct or restore function (including a congenital abnormality). Socially avoidant behaviors do not classify a surgery as reconstructive.

- Repair of cleft lip and palate is considered reconstructive regardless of functional limitations.

CHEMICAL PEELS

The following are considered **Medically Necessary:**

1. Dermal chemical peels used to treat patients with numerous (greater than 10) actinic keratoses or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical.

2. Epidermal chemical peels used to treat patients with active acne that has failed a trial of topical and/or oral antibiotic acne therapy. In this setting, superficial chemical peels with 50–70% alpha hydroxy acids are used as a comedolytic therapy. *(Alpha hydroxy acids can also be used in lower concentrations [8%] without the supervision of a physician).*

LIPECTOMY

Lipectomy and liposuction for the excision/removal of excess skin and/or subcutaneous fat may be considered medically necessary when:

1. The excess skin/fat is causing functional impairment (such as pain, inability to perform activities of daily living, chronic rashes, or skin ulceration).

2. The member has failed conservative treatments.

TREATMENT OF BENIGN SKIN LESIONS

Treatment of benign skin lesions may be considered medically necessary when one or more of the following criteria are met:

1. The lesion has one or more of the following characteristics:

    - Bleeding.
    - Change in appearance.
    - Itching.
    - Pain.

2. The lesion has physical evidence of inflammation or infection, e.g., purulence, oozing, edema, erythema, etc.
3. The lesion obstructs an orifice.
4. The lesion clinically restricts eye function. For example, the lesion:

    - Causes misdirection of eyelashes or eyelid.
    - Interferes with vision.
    - Restricts eyelid function.
    - Restricts lacrimal puncta and interferes with tear flow.
    - Touches the globe.

5. There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on lesion appearance.

6. A prior histological exam or biopsy suggests or is indicative of atypia (e.g., atypical nevus) or malignancy.

7. The lesion is in an anatomical region subject to recurrent physical trauma, and there is documentation that such trauma has occurred.

8. Wart removals will be covered under guidelines (1-7) above. In addition, wart destruction will be covered when any of the following clinical circumstances are present:

    a) Lesions are condyloma acuminata or molluscum contagiosum.

    b) Periocular warts associated with chronic recurrent conjunctivitis thought to be secondary to lesion virus shedding.

    c) Warts showing evidence of spreading from one body area to another, particularly in immunosuppressed individuals.

    d) Cervical dysplasia or pregnancy is associated with genital warts.

SERVICES/CONDITIONS GENERALLY CONSIDERED COSMETIC

In general, the following conditions/procedures are considered cosmetic and not eligible under the Member's benefit plan:

- Birthmarks, blemishes.
- Botox for wrinkles.
- Breast augmentation/lift except when provided as part of post-mastectomy reconstructive services.
- Brow lift.
- Chemical peeling except when treating malignant or pre-malignant lesions.
- Collagen injections or implants.
- Dermabrasion (including treatment of acne scarring, but excluding the correction of defects from traumatic injury, surgery or disease).
- Diastasis recti repair.
- Electrolysis.

- Excision or repair of excess or sagging skin except Panniculectomy.
- Excisions of benign skin lesions and Moles/nevi (excluding suspicious or atypical moles/dysplastic nevi).
- Face lifts or related procedures to diminish the aging process.
- Fat grafts, unless an integral part of another covered procedure.
- Hair transplants or repair of any congenital or acquired hair loss, including hair analysis (except when performed following a burn injury, trauma, or tumor removal to correct hair loss related to the injury.
- Labial Hypertrophy.
- Laser facial resurfacing.
- Laser hair removal.
- Orthodontic treatment, even when provided along with reconstructive surgery.
- Otoplasty.
- Removal (any method) for excessive hair growth, even if caused by underlying medical condition.
- Rhinophyma treatment.
- Rhytidectomy (wrinkle removal).
- Salabrasion.
- Spider vein treatment.
- Tattoo removal.
- Torn ear lobe repair.

POLICY GUIDELINES

Per DHS: any requests for services that do not meet criteria set in the PARP will be evaluated on a case-by-case basis.

In all cases, the appropriate documentation supporting medical necessity must be kept on file and, upon request, presented to us.

The definition of medical necessity may vary by product due to state and federal regulatory requirements.

- 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.

- Cosmetic surgery is performed on normal structures of the body primarily to improve appearance and/or self-esteem rather than to restore the anatomy and/or functions of the body that are lost or impaired due to an illness or injury. Cosmetic services are generally excluded from coverage in all places of service within the Member's benefit document for all lines of business.

- Services that repair a defect that developed as a result of an injury or illness may be considered reconstructive. Reconstructive surgery is often performed on burn and accident victims. It may involve the rebuilding of fractured bones, as well as skin grafting. Reconstructive surgery includes procedures such as the re-attachment of an amputated finger or toe or implanting a prosthesis. It is generally performed to improve function but also attempts to approximate a normal appearance.

- **Ambulatory Surgery Center:** Exclusion for plastic or cosmetic surgery for beautification purposes—for example, otoplasty for protruding ears or lop ears, rhinoplasty—except for internal nasal deformity—nasal reconstruction, excision of keloids, mammoplasty, silicone or silastic implants, dermabrasion, skin grafts and lipectomy. Plastic surgery is compensable if performed for the purpose of improving the functioning of a deformed body member.

- **Inpatient:** Plastic or cosmetic surgery for beautification purposes—for example, otoplasty for protruding ears or lop ears, rhinoplasty—except for internal nasal deformity—nasal reconstruction, excision of keloids, reduction mammoplasty, augmentation mammoplasty, silicone or silastic implants, fascioplasty, osteoplasty—prognathism and micrognathism—dermabrasion, skin grafts and lipectomy. For accidental injury, plastic surgery is compensable if performed for the purpose of improving the functioning of a deformed body member.

- **MEDICARE BENEFIT POLICY MANUAL CHAPTER 16, SECTION 120:** Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.

- **PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES:** DHS defines Cosmetic Services and excludes them under Physician Services in 55 PA Code §1141.59(13), as an Inpatient in §1163.59(a)(5), and in an ASC under 1126.54(a)(9).

- **Physician Services:** Cosmetic Surgery as defined in §1141.2(definitions) is listed as non-compensable. Cosmetic surgery — refers to a surgical procedure the primary purpose of which is to improve the appearance of the patient. The procedures include, but are not limited to, otoplasty for protruding ears or lop ears, rhinoplasty, except to correct internal nasal deformity, nasal reconstruction, excision of keloids, fascioplasty, osteoplasty for prognathism or micrognathism or both, dermabrasion, skin grafts and lipectomy.

CODING

Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

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CPT Code	Description
11201	REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; EACH ADDITIONAL 10 LESIONS, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

CPT Code	Description
11920	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; 6.0 SQ CM OR LESS
11921	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; 6.1 TO 20.0 SQ CM
11922	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; EACH ADDITIONAL 20.0 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
11950	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 1 CC OR LESS
11951	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 1.1 TO 5.0 CC
11952	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 5.1 TO 10.0 CC
11954	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); OVER 10.0 CC
11960	INSERTION OF TISSUE EXPANDER(S) FOR OTHER THAN BREAST, INCLUDING SUBSEQUENT EXPANSION
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)
15781	DERMABRASION; SEGMENTAL, FACE
15782	DERMABRASION; REGIONAL, OTHER THAN FACE
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

CPT Code	Description
15789	CHEMICAL PEEL, FACIAL; DERMAL
15792	CHEMICAL PEEL, NONFACIAL; EPIDERMAL
15793	CHEMICAL PEEL, NONFACIAL; DERMAL
15820	BLEPHAROPLASTY, LOWER EYELID;
15821	BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED FAT PAD
15822	BLEPHAROPLASTY, UPPER EYELID
15823	BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN WEIGHTING DOWN LID
15824	RHYTIDECTOMY; FOREHEAD
15825	RHYTIDECTOMY; NECK WITH PLATYSMAL TIGHTENING (PLATYSMAL FLAP, P-FLAP)
15826	RHYTIDECTOMY; GLABELLAR FROWN LINES
15828	RHYTIDECTOMY; CHEEK, CHIN, AND NECK
15829	RHYTIDECTOMY; SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM (SMAS) FLAP
15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY
15832	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); THIGH
15833	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); LEG
15834	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); HIP
15835	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); BUTTOCK
15836	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ARM
15837	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); FOREARM OR HAND
15838	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); SUBMENTAL FAT PAD
15839	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); OTHER AREA
15847	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY), ABDOMEN (EG, ABDOMINOPLASTY) (INCLUDES UMBILICAL TRANSPOSITION AND FASCIAL PLICATION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
15876	SUCTION ASSISTED LIPECTOMY; HEAD AND NECK

CPT Code	Description
15877	SUCTION ASSISTED LIPECTOMY; TRUNK
15878	SUCTION ASSISTED LIPECTOMY; UPPER EXTREMITY
15879	SUCTION ASSISTED LIPECTOMY; LOWER EXTREMITY
17106	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); LESS THAN 10 SQ CM
17107	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); 10.0 TO 50.0 SQ CM
17108	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); OVER 50.0 SQ CM
17110	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), OF BENIGN LESIONS OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; UP TO 14 LESIONS
17111	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), OF BENIGN LESIONS OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PR OLIFERATIVE LESIONS; 15 OR MORE LESIONS
17360	CHEMICAL EXFOLIATION FOR ACNE (EG, ACNE PASTE, ACID)
17380	ELECTROLYSIS EPILATION, EACH 30 MINUTES
19300	MASTECTOMY FOR GYNECOMASTIA
19316	MASTOPEXY
19318	REDUCTION MAMMAPLASTY
19325	MAMMAPLASTY, AUGMENTATION; WITH PROSTHETIC IMPLANT
19328	REMOVAL OF INTACT MAMMARY IMPLANT
19330	REMOVAL OF MAMMARY IMPLANT MATERIAL
19340	IMMEDIATE INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR IN RECONSTRUCTION
19342	DELAYED INSERTION OF BREAST PROSTHESIS FOLLOWING MASTOPEXY, MASTECTOMY OR IN RECONSTRUCTION
19350	NIPPLE/AREOLA RECONSTRUCTION
19355	CORRECTION OF INVERTED NIPPLES
19357	BREAST RECONSTRUCTION, IMMEDIATE OR DELAYED, WITH TISSUE EXPANDER, INCLUDING SUBSEQUENT EXPANSION
19361	BREAST RECONSTRUCTION WITH LATISSIMUS DORSI FLAP, WITHOUT PROSTHETIC IMPLANT
19364	BREAST RECONSTRUCTION WITH FREE FLAP

CPT Code	Description
19367	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP (TRAM), SINGLE PEDICLE, INCLUDING CLOSURE OF DONOR SITE;
19368	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP (TRAM), SINGLE PEDICLE, INCLUDING CLOSURE OF DONOR SITE; WITH MICROVASCULAR ANASTOMOSIS (SUPERCHARGING)
19369	BREAST RECONSTRUCTION WITH TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS FLAP (TRAM), DOUBLE PEDICLE, INCLUDING CLOSURE OF DONOR SITE
19370	OPEN PERIPROSTHETIC CAPSULOTOMY, BREAST
19371	PERIPROSTHETIC CAPSULECTOMY, BREAST
19380	REVISION OF RECONSTRUCTED BREAST
19396	PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT
21085	IMPRESSION AND CUSTOM PREPARATION; ORAL SURGICAL SPLINT
21120	GENIOPLASTY; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, PROSTHETIC MATERIAL)
21121	GENIOPLASTY; SLIDING OSTEOTOMY, SINGLE PIECE
21122	GENIOPLASTY; SLIDING OSTEOTOMIES, 2 OR MORE OSTEOTOMIES (EG, 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
21141	RECONSTRUCTION MIDFACE, LEFORT I; SINGLE PIECE, SEGMENT MOVEMENT IN ANY DIRECTION (EG, FOR LONG FACE SYNDROME), WITHOUT BONE GRAFT
21142	RECONSTRUCTION MIDFACE, LEFORT I; 2 PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, WITHOUT BONE GRAFT
21143	RECONSTRUCTION MIDFACE, LEFORT I; 3 OR MORE PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, WITHOUT BONE GRAFT
21145	RECONSTRUCTION MIDFACE, LEFORT I; SINGLE PIECE, SEGMENT MOVEMENT IN ANY DIRECTION, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)

CPT Code	Description
21146	RECONSTRUCTION MIDFACE, LEFORT I; 2 PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS) (EG, UNGRAFTED UNILATERAL ALVEOLAR CLEFT)
21147	RECONSTRUCTION MIDFACE, LEFORT I; 3 OR MORE PIECES, SEGMENT MOVEMENT IN ANY DIRECTION, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS) (EG, UNGRAFTED BILATERAL ALVEOLAR CLEFT OR MULTIPLE OSTEOTOMIES)
21150	RECONSTRUCTION MIDFACE, LEFORT II; ANTERIOR INTRUSION (EG, TREACHER-COLLINS SYNDROME)
21151	RECONSTRUCTION MIDFACE, LEFORT II; ANTERIOR INTRUSION (EG, TREACHER-COLLINS SYNDROME)
21154	RECONSTRUCTION MIDFACE, LEFORT III (EXTRACRANIAL), ANY TYPE, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS); WITHOUT LEFORT I
21155	RECONSTRUCTION MIDFACE, LEFORT III (EXTRACRANIAL), ANY TYPE, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS); WITH LEFORT I
21159	RECONSTRUCTION MIDFACE, LEFORT III (EXTRA AND INTRACRANIAL) WITH FOREHEAD ADVANCEMENT (EG, MONO BLOC), REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS); WITHOUT LEFORT I
21160	RECONSTRUCTION MIDFACE, LEFORT III (EXTRA AND INTRACRANIAL) WITH FOREHEAD ADVANCEMENT (EG, MONO BLOC), REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS); WITH LEFORT I
21188	RECONSTRUCTION MIDFACE, OSTEOTOMIES (OTHER THAN LEFORT TYPE) AND BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)
21193	RECONSTRUCTION OF MANDIBULAR RAMI, HORIZONTAL, VERTICAL, C, OR L OSTEOTOMY; WITHOUT BONE GRAFT
21194	RECONSTRUCTION OF MANDIBULAR RAMI, HORIZONTAL, VERTICAL, C, OR L OSTEOTOMY; WITH BONE GRAFT (INCLUDES OBTAINING GRAFT)
21195	RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITHOUT INTERNAL RIGID FIXATION
21196	RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITH INTERNAL RIGID FIXATION
21198	OSTEOTOMY, MANDIBLE, SEGMENTAL
21199	OSTEOTOMY, MANDIBLE, SEGMENTAL; WITH GENIOGLOSSUS ADVANCEMENT
21206	OSTEOTOMY, MAXILLA, SEGMENTAL (EG, WASSMUND OR SCHUCHARD)
21208	OSTEOPLASTY, FACIAL BONES; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, OR PROSTHETIC IMPLANT)
21209	OSTEOPLASTY, FACIAL BONES; REDUCTION

CPT Code	Description
21210	GRAFT, BONE; NASAL, MAXILLARY OR MALAR AREAS (INCLUDES OBTAINING GRAFT)
21215	GRAFT, BONE; MANDIBLE (INCLUDES OBTAINING GRAFT)
21230	GRAFT; RIB CARTILAGE, AUTOGENOUS, TO FACE, CHIN, NOSE OR EAR (INCLUDES OBTAINING GRAFT)
21235	GRAFT; EAR CARTILAGE, AUTOGENOUS, TO NOSE OR EAR (INCLUDES OBTAINING GRAFT)
21270	MALAR AUGMENTATION, PROSTHETIC MATERIAL
21275	SECONDARY REVISION OF ORBITOCRANIOFACIAL RECONSTRUCTION
21280	MEDIAL CANTHOPEXY (SEPARATE PROCEDURE)
21282	LATERAL CANTHOPEXY
30120	EXCISION OR SURGICAL PLANING OF SKIN OF NOSE FOR RHINOPHYMA
30400	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR ELEVATION OF NASAL TIP
30410	RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL PARTS INCLUDING BONY PYRAMID, LATERAL AND ALAR CARTILAGES, AND/OR ELEVATION OF NASAL TIP
30420	RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPTAL REPAIR
30430	RHINOPLASTY, SECONDARY; MINOR REVISION (SMALL AMOUNT OF NASAL TIP WORK)
30435	RHINOPLASTY, SECONDARY; INTERMEDIATE REVISION (BONY WORK WITH OSTEOTOMIES)
30450	RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK AND OSTEOTOMIES)
30520	SEPTOPLASTY OR SUBMUCOUS RESECTION, WITH OR WITHOUT CARTILAGE SCORING, CONTOURING OR REPLACEMENT WITH GRAFT
30620	SEPTAL OR OTHER INTRANASAL DERMATOPLASTY (DOES NOT INCLUDE OBTAINING GRAFT)
31830	REVISION OF TRACHEOSTOMY SCAR
36468	SINGLE OR MULTIPLE INJECTIONS OF SCLEROSING SOLUTIONS, SPIDER VEINS (TELANGIECTASIA); LIMB OR TRUNK
36470	INJECTION OF SCLEROSANT; SINGLE INCOMPETENT VEIN (OTHER THAN TELANGIECTASIA)
36471	INJECTION OF SCLEROSANT; MULTIPLE INCOMPETENT VEINS (OTHER THAN TELANGIECTASIA) SAME LEG
49250	UMBILECTOMY, OMPHALECTOMY, EXCISION OF UMBILICUS (SEPARATE PROCEDURE)

CPT Code	Description
67900	REPAIR OF BROW PTOSIS (SUPRACILIARY, MID-FOREHEAD OR CORONAL APPROACH)
67901	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH SUTURE OR OTHER MATERIAL (EG, BANKED FASCIA)
67902	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH AUTOLOGOUS FASCIAL SLING (INCLUDES OBTAINING FASCIA)
67903	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, INTERNAL APPROACH
67904	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, EXTERNAL APPROACH
67906	REPAIR OF BLEPHAROPTOSIS; SUPERIOR RECTUS TECHNIQUE WITH FASCIAL SLING (INCLUDES OBTAINING FASCIA)
67908	REPAIR OF BLEPHAROPTOSIS; CONJUNCTIVO-TARSO-MULLER'S MUSCLE-LEVATOR RESECTION (EG, FASANELLA-SERVAT TYPE)
67909	REDUCTION OF OVERCORRECTION OF PTOSIS
67911	CORRECTION OF LID RETRACTION
67923	REPAIR OF ENTROPION; EXCISION TARSAL WEDGE
67950	CANTHOPLASTY (RECONSTRUCTION OF CANTHUS)
69300	OTOPLASTY, PROTRUDING EAR, WITH OR WITHOUT SIZE REDUCTION

HCPCS Code	Description
C1789	PROSTHESIS, BREAST (IMPLANTABLE)
J0585	INJECTION, ONABOTULINUMTOXINA, 1 UNIT
J0586	INJECTION, ABOBOTULINUMTOXINA, 5 UNITS
J0587	INJECTION, RIMABOTULINUMTOXINB, 100 UNITS
J0588	INJECTION, INCOBOTULINUMTOXINA, 1 UNIT
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit
L8600	IMPLANTABLE BREAST PROSTHESIS, SILICONE OR EQUAL

ICD 10 Codes	Description
N/A	N/A

BENEFIT APPLICATION

Medical policies do not constitute a description of benefits. This medical necessity policy assists in the administration of the members' benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage. This policy is invoked only when the requested service is an eligible benefit as defined in the Member's applicable benefit contract on the date the service was rendered. Services determined by the Plan to be investigational or experimental, cosmetic, or not medically necessary are excluded from coverage for all lines of business.

DESCRIPTION OF SERVICES

This policy describes considerations in determining when services are cosmetic.

DEFINITIONS

- **Cosmetic Surgery:** Surgery performed to reshape normal structure of the body in order to improve the patient's appearance and self-esteem.
- **Functional impairment:** Functional impairment is a deviation from the normal utility of a tissue, organ, or body part. It results in a significantly limited, impaired, or delayed ability to move, coordinate actions, or performs physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.
- **Reconstructive surgery:** Reconstructive surgery is performed on abnormal structures of the body caused by congenital deformity, trauma, infection, tumors, or disease. It is generally performed to improve function but may also be done to approximate a normal appearance.

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making. Policy Bulletins are

developed to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Policy Bulletin may be updated and therefore is subject to change.

For Jefferson Health Plans EverWell and Jefferson Health Plans CHIP products: Any request for services that do not meet criteria set in PARP will be evaluated on a case-by-case basis.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Effective Date
2026 Adhoc review. Significant code revisions were made, including the removal of multiple codes and the addition of codes 21154, 21155, 21159, and 21160.	J	12/07/2026
2026 Annual Review. Codes: 15819, C9160, C9784, Q4100 removed as they are no longer active.	I	04/15/2026
2025 Annual review. Product variation statement updated. Disclaimer statement updated.	I	04/17/2024
2024 Annual review. Language added related to wart removals. Code J0589 was added.	I	04/17/2024
7/1/23 Code update. C9784 & C9785 were added.	H	09/01/2023
2023 Annual review. No changes. Reissue as written.	G	10/15/2021
2022 Annual review. Product Variations section updated to include: L34924-Treatment of Chronic Venous Insufficiency of the Lower Extremities. References section updated. No other changes to policy content.	G	10/15/2021
2021 ad hoc review. The following codes were removed from the coding table: 11400, 11401, 11402, 11403, 11404, 11406, 11420, 11421, 11422, 11423, 11424, 11426, 11440, 11441, 11442, 11443, 11444, 11446.	G	10/15/2021
2021 Annual policy review. No changes to the policy language. The following codes are no longer active and were removed from the coding table: 19324, 19366, 36469.	F	05/01/2020

Summary	Version	Effective Date
2020 Annual policy review. The following codes were added to the coding table: 15771, 15772, 15773, 15774.	F	05/01/2020
2019 Annual policy review. Policy language remains the same. Reissue for 2019.	E	11/01/2018
2018 Annual policy review. Septoplasty and circumcision removed from prior authorization, but codes 30520 & 54161 will remain in the policy.	E	11/01/2018
Photodynamic Therapy codes (96567, 96573, and 96574) have been removed because they are now covered for certain indications.	D	01/01/2018
• Policy revised to remove the deleted code: 36469. • Codes 54406, 54408, and 54415 were removed based on NCD 230.4 Diagnosis and Treatment of Impotence which now considers the service medically necessary when criteria are met. • Prior authorization requirements for 17110 and 17111 removed from guideline section.	C	10/13/2016
Codes considered potentially cosmetic in Claim Check Edit added to policy for consistency (10040, 21083, 67911, S0800). ▪ No change in coverage criteria. ▪ Language in Guideline section for benign skin lesions (17110, 17111) added to policy.	B	08/01/2016
New Policy.	A	07/27/2016

REFERENCES

1. Centers for Medicare & Medicaid Services (CMS) **Medicare Benefit Manual (Pub.100-2), Chapter 16**, § 120 - Cosmetic Surgery; **CMS.gov Medicare Benefit Policy Manual Chapter 16**

2. Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD) **NCD 140.2** - Breast Reconstruction Following Mastectomy.

https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=64&ncdver=1&bc=AAAAgAAAAAAAAA%3d%3d&

3. Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD) **NCD 250.5** Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=338&ncdver=1&bc=AAAAgAAAAAAAAA%3d%3d&

4. Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD) **NCD 140.4** - Plastic Surgery to Correct "Moon Face". https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=14&ncdver=1&bc=AAAAgAAAAAAAAA%3d%3d&

5. Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD) **NCD 250.4** - Treatment of Actinic Keratosis **https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=129&ncdver=1&bc=AAAAgAAAAAAAAA%3d%3d&**

6. Novitas Solutions, Local Coverage Determination (LCD) **L35090** Cosmetic and Reconstructive Surgery. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=35090&ver=95&bc=0

7. Novitas Solutions, Local Coverage Determination (LCD) - **L34938** - Removal of Benign or Premalignant Skin Lesions. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=34938&ver=68&bc=0

8. Novitas Solutions, Local Coverage Determination (LCD) **L35004** - Surgery: Blepharoplasty: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=35004&ver=23&bc=0

9. Novitas Solutions, Local Coverage Determination (LCD) **L34924** Treatment of Chronic Venous Insufficiency of the Lower Extremities https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34924

10. Pennsylvania Code. § 1163.59. Noncompensable services, items, and outlier days. **The Pennsylvania CODE Noncompensable Services, items, and outlier days**