

Cosmetic and Reconstructive Surgery

Policy Number: PG0104
Last Review: 11/01/2024

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

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. The presence or absence of a functional impairment is a critical element in the consideration of medical necessity for the surgery. 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,

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, but some dermatologic conditions may significantly alter the function of the skin; one example is pemphigus, which impairs the fluid balance of the body.

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:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

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.**

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.

- Cosmetic Services performed solely to improve one's appearance and/or self-esteem are considered not medically necessary and therefore not covered

Providers must refer to the Paramount Prior Authorization-Experimental/Investigational-NonCovered excel spreadsheet, <https://pcl.promedica.org/-/media/paramount/assets/documents/provider/prior-authorization-list.pdf?rev=e7080c8448f94d49bc313cb4a65db7aa&hash=C405FDECB4FA6712F0CFD28F9BC65985>, and specific medical policies, <https://www.paramounthealthcare.com/providers/medical-policies/policy-library>, in reference to specific procedures as indicated below (this list may not be all-inclusive).

- Procedure codes that require a prior authorization: 15775, 15776, 15824, 15825, 15826, 15828, 15829, G0429, Q2026, Q2028
- Procedure codes that are noncovered: 15773, 15774, 15786, 15787, 15819, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 15876, 15877, 15878, 15879, 17380, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21256, 21260, 21261, 21263, 21267, 21268, 21280, 21282, 30120, 69090, 0419T, 0420T, 0437T, L8607

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.

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

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:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

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-Experimental/Investigational-NonCovered excel spreadsheet 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 experimental/investigational, cosmetic or not medically necessary services and will not reimburse for any services, procedures, drugs or supplies associated with those experimental/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.

| Paramount Commercial Insurance Plans and Medicare Advantage Plans | | |
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| <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> | | |
| Procedures | | |
| Abdominoplasty A tummy tuck, also known as abdominoplasty, removes excess fat and skin and restores weakened muscles to create a smoother, firmer abdominal profile. | | |
| Adipose-Derived Regenerative Cell (ADRC) Therapy (i.e., Habeo Cell Therapy) | | |
| Aesthetic alteration of the female genitalia (e.g., hymenoplasty, inverted V hoodoplasty, labiaplasty, and mons pubis pexy) | | |
| Aesthetic operations on umbilicus | | |
| Age spot treatments | | |
| Alopecia When alopecia is caused by a systemic illness or by a skin disease of the scalp, the treatment of that illness is covered. The treatment of alopecia that is cosmetic (male or female pattern baldness) is not covered. In no case will drugs designed to grow more hair (whether taken by mouth or applied to the scalp), prosthetics, or surgical transplantation be covered. | | |
| Birthmark/blemish treatment | | |
| Blepharoplasty (eyelid surgery) when not medically indicated | | |
| Body Lifts 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 | | |
| Botox for wrinkles 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 | | |

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| <p>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.</p> <p>OnabotulinumtoxinA (Botox®), AbobotulinumtoxinA (Dysport™), RimabotulinumtoxinB (Myobloc®), and Incobotulinum</p> <p>Note: Coverage for Botulinum toxin injections may be indicated for medical coverage indications through the pharmacy department coverage policies.</p> <p>Botulinum toxins are potent neuromuscular blocking agents that are useful in treating various focal muscle spastic disorders and excessive muscle contractions, such as dystonia, spasms, and twitches. They produce a presynaptic neuromuscular blockade by preventing the release of acetylcholine from the nerve endings. Since the resulting chemical denervation of muscle produces local paresis or paralysis, selected muscles can be treated. Botulinum toxins are used in the treatment of overactive skeletal muscles, smooth muscles, and glands.</p> <p>https://www.paramounthealthcare.com/services/providers/prescription-drug-benefits/</p> | | |
| <p>Breast augmentation (enlargement), elective</p> <p>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> | | |
| <p>Breast Implant Revision</p> <p>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> | | |
| <p>Breast Implant Removal</p> <p>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> | | |
| <p>Breast lift (mastopexy)</p> <p>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 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>Breast reduction</p> <p>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> | | |
| <p>Calf augmentation (restore leg contour)</p> <p>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>Buttock lift or augmentation</p> <p>Is used to improve the contour, size and/or shape of the buttocks. This is done using 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 using 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>Canthopexy or Canthoplasty (lower eyelid tightening)</p> | | |

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| Cheek implant (malar implant/augmentation) (eg, Juvederm, Restylane) 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. | | |
| Chemical peels (chemical exfoliation) (Treatments aimed solely at improving personal appearance/acne treatments) | | |
| Chin implant (genioplasty, mentoplasty) | | |
| Collagen implant | | |
| Collagenase clostridium histolyticum-aaes (Qwo, Endo Aesthetics LLC) injection for treatment of moderate to severe cellulite in the buttocks | | |
| Cool sculpting (may also be known as cryolipolysis or fat freezing) | | |
| Correction of diastasis recti abdominis <ul style="list-style-type: none"> 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. Repair of a true incisional or ventral hernia is considered medically necessary. | | |
| Correction of inverted nipple, unless related to cancer surgery | | |
| Cryotherapy for benign skin lesions | | |
| Dermabrasion (acne scarring, fine wrinkles, rhytids, and tattoo removal) Dermabrasion (that is, abrasion, salabrasion) is considered medically necessary for the treatment of actinic keratoses, other pre-malignant skin lesions and localized non-melanoma malignant skin lesions. Examples include, but are not limited to, basal cell carcinoma and carcinoma in-situ. Dermabrasion or salabrasion is considered cosmetic and not medically necessary when performed in the absence of a significant functional impairment and are intended to change a physical appearance that would be considered within normal human anatomic variation. Examples include, but are not limited to, enhance the appearance of the upper layer of the skin because of acne, acne scars, uneven pigmentation or wrinkles. | | |
| Deoxycholic acid injection (e.g., Kybella) | | |
| Ear or body piercing | | |
| 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. Considered cosmetic when submental fat in adults (i.e., double chin) treated with Kybella T M (deoxycholic acid) injections. | | |
| Female Sexual Dysfunction (FSD) <ul style="list-style-type: none"> Bibliotherapy Biothesiometry Botulinum toxin Female erectile devices (e.g., Eros clitoral stimulation device) Gene therapy Growth factor therapy Hyaluronic acid Laser therapy (e.g., Micro-ablative carbon dioxide laser) Oxytocin Percutaneous tibial nerve stimulation Phosphodiesterase type 5 inhibitors (e.g., sildenafil, tadalafil, and vardenafil) Progesterone | | |

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| <ul style="list-style-type: none"> • Radiofrequency thermal therapy (e.g., the ThermiVa procedure, and the Viveve procedure) • Regenerative medicine • Sacral neuromodulation • Stem cell-based therapies • Testosterone therapy (implant or injection) • Topical lidocaine • Transcranial direct current • Vaginal electrical stimulation <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 affect 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-spot." The field of nonsurgical female genital rejuvenation is growing as the change women experience receive greater attention</p> | | |
| <p>Forehead reduction, contouring, contouring and application of contouring material or bone graft (includes obtaining autograft), and contouring and setback of anterior frontal sinus wall.</p> <p>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.</p> | | |
| <p>Gynecomastia surgery</p> <p>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.</p> | | |
| <p>Hair transplants/replacements (a variety of techniques, including punch grafts)</p> <p>Punch graft hair transplant may be covered for burn injury, tumor removal or trauma</p> | | |
| <p>Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall</p> | | |
| <p>Injectable fillers (Dermal Fillers) (i.e., Radiesse, Sculptra)</p> <p>May be considered reconstructive when:</p> <ul style="list-style-type: none"> • 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. • 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; Julesse™ Laryngeal Implant). <p>Considered cosmetic when injectable dermal fillers used to sculpt or smooth body and/or facial contours (e.g., Radiesse®, Sculptra®) for all other indications</p> | | |
| <p>Intense pulsed light laser for facial redness</p> | | |
| <p>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.</p> <p>May be considered reconstructive when:</p> <ul style="list-style-type: none"> • Ulceration or infection with or without sinus tracts; • Extremely large, painful keloid associated with stretching; • Rapid growth of the keloid interferes with normal function. <p>Considered cosmetic when removal of small keloid which does not interfere with normal function.</p> | | |
| <p>Lacrimal gland resuspension for lacrimal gland prolapse</p> | | |

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| <p>Laser skin resurfacing (also known as laser peel, laser vaporization) to reduce wrinkles, scars and blemishes including but not limited to the following:</p> <ul style="list-style-type: none"> • Acne scarring • Age spots/brown spots • Melasma (brown to grey-brown patches on the face) • Rosacea • Vitiligo • Wrinkles; and <p>Skin rejuvenation and resurfacing/targeted phototherapy using laser therapy to include but not limited to the treatment of rosacea, 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"> • Laser (Excimer laser) and Intense Light (IPL) Treatments (used to remove discoloration and/or tighten sagging skin) • Chemical peels (various acid peels used in different combinations to remove damaged outer skin layers) • Ablative laser treatments (fractional, CO2 lasers [remove outer layers of skin to smooth lines and wrinkles]) • Mechanical ablation (dermabrasion, dermaplaning [surgical scraping methods to soften skin surface irregularities]) • Non-ablative treatments (microdermabrasion, microneedling, light acid peels [minimally invasive sanding methods to treat light scarring and discolorations]) | | |
| <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>Lipomas Excision is considered medically necessary if lipomas are tender and inhibit the member's ability to perform daily activities due to the lipomas' location on body parts that are subject to regular touch or pressure.</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. The Renuvion device (previously branded as J-Plasma handpiece) for use with liposuction is considered experimental/investigational.</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/m² is not medically necessary. Reconstructive surgery (i.e., excision of excessive skin) following obesity surgery (15831–15839) is not a covered benefit.</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.</p> | | |

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| Complementary and alternative medicine treatments are considered investigational and are not covered as a treatment of any condition. Additionally, mesotherapy is considered cosmetic for all indications. | | |
| 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 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"> • Considered cosmetic when there is no interference with normal function. • Considered reconstructive when the following conditions exist that may interfere with normal function such as: <ul style="list-style-type: none"> ◦ Symptomatic neurofibromas (painful, tender, infected). | | |
| Nonsurgical fat reduction (minimally invasive procedures) 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 is 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: <ul style="list-style-type: none"> • Cryolipolysis (e.g., CoolSculpting) • Injection lipolysis (e.g., Kybella), • Radiofrequency lipolysis (e.g., Vanquish) • Laser lipolysis (e.g., SculpSure) | | |
| Otoplasty/Pinnaplasty May be considered reconstructive when: <ul style="list-style-type: none"> • Ears are absent; or • Deformed from trauma, surgery, disease or congenital defects • 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). Considered cosmetic when performed to correct large or protruding ears. | | |
| Panniculectomy Considered cosmetic when performed for aesthetic purposes – to solely improve the patient's appearance in the absence of symptoms or functional abnormalities/impairments. | | |
| 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 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. | | |
| Pulsed-dye laser treatment and excision of port wine stains and other hemangiomas Except considered medically necessary when atypical or causing functional limitation (i.e., affects vision, breathing, hearing, ability to eat, bleeding, ulceration, and/or infection). | | |
| Refractive Surgery (Lasik, PRK, PTK) Considered cosmetic when the vision can be adequately corrected using corrective lenses or contact lenses. | | |
| Removal of frown lines (Excision or correction of glabella frown lines) | | |
| Removal of spider angiomas | | |

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| <p>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"> • Sclerotherapy (Asclera, Sotradecol) • Laser treatments <ul style="list-style-type: none"> ○ PhotoDerm ○ VeinLase ○ Vasculite • Focused thermal energy <ul style="list-style-type: none"> ○ Veinwave ○ VeinGogh Thermolysis System | | |
| Removal of supernumerary nipples (polymastia) | | |
| <p>Rhytidectomy (including meloplasty, face lift)</p> <p>May be considered reconstructive when:</p> <ul style="list-style-type: none"> • For treatment of burns <p>Considered cosmetic when preformed for treatment of the face for aging skin.</p> | | |
| <p>Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap (facelift)</p> <p>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> | | |
| Salabrasion | | |
| 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 | | |
| Selective neurectomy of the gastrocnemius muscle for correction of calf hypertrophy | | |
| <p>Septoplasty and Rhinoplasty</p> <ul style="list-style-type: none"> • 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. • 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. | | |
| <p>Skin tag removal (Acrochordon)</p> <p>May be considered reconstructive when:</p> <ul style="list-style-type: none"> • Skin tag removal when located in an area of friction with documentation of repeated irritation and bleeding | | |
| Surgery for body dysmorphic disorder | | |
| 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 | | |
| <p>Tattoo placement</p> <p>Considered medically necessary in conjunction with reconstructive breast surgery post-mastectomy, and for marking for radiation therapy.</p> | | |
| Tattoo removal (laser treatments, chemical peels, dermabrasion and surgical excision) | | |

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| 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 (azfidel-T) Laviv (azfidel-T) is an autologous cellular product, treatment with autologous fibroblasts grown in culture (azfidel-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 treatment: related to phototherapy is non-covered for cosmetic treatment. | | |
| 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 | | |
| 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 affects 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. | | |

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. 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 | |
|---------------------------------------|---|
| Z40.8 | Encounter for other prophylactic surgery |
| Z40.9 | Encounter for prophylactic surgery, unspecified |
| Z41.1 | Encounter for cosmetic surgery |
| Z41.3 | Encounter for ear piercing |
| Z41.8 | Encounter for other procedures for purposes other than remedying health state |
| Z41.9 | 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.

Paramount Commercial Insurance Plans

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

Elite (Medicare Advantage) Plans

For Elite (Medicare Advantage) Plans 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.

For procedures determined to be non-covered, Elite (Medicare Advantage) Plan 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 appearance of a code in this section does not necessarily indicate coverage. 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 | |
| 11951 | Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0cc | |
| 11952 | Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0cc | |
| 11954 | Subcutaneous injection of filling material (e.g., collagen); over 10.0cc | |
| 11970 | Replacement of tissue expander with permanent prosthesis | PG0144 |
| 11971 | Removal of tissue expander(s) without insertion of prosthesis | PG0144 |

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| 15769 | Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascial) | PG0144 |
| 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 | |
| 15821 | Blepharoplasty, lower eyelid; with extensive herniated fat pad | |
| 15822 | Blepharoplasty, upper lid | |
| 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, 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 | |

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| 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 | |
| 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 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 , slush, liquid N) 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 | |
| 19303 | Simple complete mastectomy | |
| 19316 | Mastopexy | PG0144 |
| 19318 | Reduction mammoplasty | PG0144 |
| 19325 | Augmentation mammoplasty with prosthetic implant | 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 |

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| 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) | |

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| 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 | |

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| 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 | |
| 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) | |
| 30460 | Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only | |
| 30462 | Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies | |
| 30465 | Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction) | |
| 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 |

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| 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) | |
| 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 | |
| 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 |

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| 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, 18culptra, 0.5 mg | |

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 04/15/2008

| Date | Explanation & Changes |
|-------------------|---|
| 01/28/11 | <ul style="list-style-type: none"> E/M services 99201-99215 will be reimbursed when submitted with specific codes that are considered cosmetic per medical policy review |
| 07/22/11 | <ul style="list-style-type: none"> 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 |
| 09/08/15 | <ul style="list-style-type: none"> Changed title from Cosmetic Services to Cosmetic and Reconstructive Surgery 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 Added ICD-9 codes 309.1 and V50.8. ICD-10 codes added from ICD-9 conversion CPT codes 40819, 41115, 56620, 65710, 69300, 68310, 69320 removed from this policy Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee |
| 08/09/16 | <ul style="list-style-type: none"> Added L8607 as non-covered for all product lines Added code 69300 and reference to new medical policy PG0376 Otoplasty Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee |
| 01/10/17 | <ul style="list-style-type: none"> Effective 01/01/17 codes 15876, 15878, 15879 are now covered with prior authorization for Advantage only per ODM guidelines Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee |
| 05/31/19 | <ul style="list-style-type: none"> Removed diagnosis code F43.21. Diagnosis code F43.21 was inappropriately included. |
| 12/14/2020 | <ul style="list-style-type: none"> Medical policy placed on the new Paramount Medical policy format |
| 11/01/2021 | <ul style="list-style-type: none"> Removed procedure 65770, keratoprosthesis is never considered/indicated as cosmetic Removed procedure code sets 11300-11313 and 11400-11446, PG0105, reference from the CODING/BILLING INFORMATION, is not relevant to PG0104 Removed the following deleted codes 15831, 19304, 19324, 19366, C9800 Added the following codes 0419T, 0420T, 0437T, 15769, 15771, 15772, 15773, 15774, 19120, 30124, 49250, 56800, L8603 related to cosmetic and reconstructive surgery reference Effective December 1st, 2021 procedures 15773 and 15774 will require a prior authorization for the Advantage Product line |
| 12/22/2021 | <ul style="list-style-type: none"> 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. |
| 12/23/2021 | <ul style="list-style-type: none"> Add documentations indicating when procedures 15773 and 15774 support coverage for the Advantage product |
| 04/11/2022 | <ul style="list-style-type: none"> Additional documentation added defining the coverage of dermabrasion |
| 08/23/2022 | <ul style="list-style-type: none"> Clarified the noncoverage of vitiligo r/t to MP PG0162 Phototherapy, Photochemotherapy, & Excimer Laser for Dermatologic Conditions Removed the word medication as it referenced vitiligo, as medication coverage is managed through the pharmacy benefits and policies |

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| 12/01/2022 | <ul style="list-style-type: none"> Paramount indicated Vitiligo treatment: related to phototherapy is non-covered for cosmetic treatment, referencing PG0162 Phototherapy, PUVA, UV-A & Targeted for Dermatologic Conditions Paramount added noncoverage criteria related to Alopecia, referencing PG0514 Alopecia |
| 02/07/2023 | <ul style="list-style-type: none"> Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023 |
| 03/30/2023 | <ul style="list-style-type: none"> Medical Policy updated to reflect DME limits calculated by CMS criteria/guidelines. |
| 07/13/2023 | <ul style="list-style-type: none"> Added CPT codes 15847 and 15877 as non-covered for Paramount Commercial and Medicare Advantage Plans |
| 08/16/2023 | <ul style="list-style-type: none"> Removed procedure codes 19301, 19302, 19305, 19306, 19307 from policy, procedure removed from medical policy PG0251 Prophylactic Mastectomy. |
| 02/01/2024 | <ul style="list-style-type: none"> Medical Policy placed on the new Paramount Medical Policy format |
| 11/01/2024 | <ul style="list-style-type: none"> Medical Policy reviewed and updated to industry standards Medical Policy documentation coverage/noncoverage added to the Prior Authorization-Experimental/Investigational-NonCovered excel spreadsheet Removed S-codes, S0800, S0810, S0812, S2066, S2067, S2068, S2083. Paramount does not allow/reimburse for S-codes. |

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

<https://www.paramounthealthcare.com/providers/medical-policies/policy-library>

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals>
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs>

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files>

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies <https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf>

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services <https://www.ama-assn.org/amaone/cpt-current-procedural-terminology>

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets <https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update>

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting <https://www.cms.gov/medicare/coding/icd10>

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23-Fee Schedule administration and coding Requirements <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf>

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services <https://www.cms.gov/medicare-medicare-coordination/national-correct-coding-initiative-ncci/ncci-medicare>

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) <https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits>

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U.S. Preventive Services Task Force,
<https://www.uspreventiveservicestaskforce.org/uspstf/>

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