Cosmetic and Reconstructive Procedures (for Louisiana Only)

Policy Number: CS027LA.N~~M~~
Effective Date: ~~August 1, 2019~~**TBD**

➲ Instructions for Use

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Application

This ~~Coverage Determination Guideline~~**Medical Policy** only applies to the state of Louisiana.

Coverage Rationale

~~Some states require benefit coverage for services that UnitedHealthcare considers Cosmetic Procedures, such as repair of external Congenital Anomalies in the absence of a Functional Impairment.~~

~~Indications of Coverage~~

Reconstructive Procedures

~~For plans that include benefits for Cosmetic Procedures, the following are eligible for coverage as~~**A procedure is considered** **reconstructive and ~~m~~Medically ~~n~~Necessary when all of the following criteria are met:**

- There is documentation that the physical abnormality and/or physiological abnormality is causing a Functional Impairment that requires correction; and
- The proposed treatment is of proven efficacy and is deemed likely to significantly improve or restore the patient's physiological function.

~~Microtia~~

Note: ~~Microtia~~Microtia repair is **considered** reconstructive~~.~~ although no Functional Impairment may be documented ~~for Microtia, this has been deemed Reconstructive Surgery~~.

Flap Repair

Flap repair is considered reconstructive and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Tissue Transfer (Flap).

Click here to view the InterQual® criteria.

Cosmetic Procedures ~~Coverage Limitations and Exclusions~~

The following procedures are considered cosmetic and not Medically Necessary ~~UnitedHealthcare excludes Cosmetic Procedures from coverage~~ **including but not limited to the following:**

- Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.
- Procedures that do not meet the reconstructive criteria in the **Reconstructive Procedures** ~~Indications for Coverage~~ section
- **Autologous fat transfer when performed as a Cosmetic Procedure**
- **Revision of keloids when performed as a Cosmetic Procedure**
- **Cosmetic** ~~P~~**p**harmacological regimens, nutritional procedures**,** or **nutritional** treatments
- ~~•~~ **Skin abrasion for the treatment of scars or tattoo removal or acne and other such skin abrasion procedures** ~~Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)~~
- ~~Skin abrasion procedures performed as a treatment for acne~~
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin
- ~~Treatment for spider veins~~
- Hair removal or replacement by any means **except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria. (Note: For laser or electrolysis hair removal (CPT codes 17380 and 17999) in advance of genital reconstruction, refer to the Medical Policy titled Gender Dysphoria Treatment.**

Definitions

Check the definitions within the **federal, state, and contractual requirements** ~~member benefit plan document~~ that supersede the definitions below.

Adjacent Tissue Transfer: A random pattern local flap which is used to fill in nearby or local defect. To be considered an adjacent tissue transfer an incision must be made by the surgeon which results in a secondary defect. Examples include; transposition flaps, advancement flaps and rotation flaps.

Congenital Anomaly: A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function.

Cosmetic Surgery: Defined by the American Society of Plastic Surgeons, "is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem."

Functional or Physical Impairment: A Functional or Physical or physiological Impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

Injury: Damage to the body, including all related conditions and symptoms.

Medically Necessary: Health care services that are all of the following as determined by UnitedHealthcare or our designee:

- **In accordance with Generally Accepted Standards of Medical Practice.**
- **Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for the member's Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.**
- **Not mainly for the member's convenience or that of the member's doctor or other health care provider.**
- **Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.**

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare has the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by UnitedHealthcare.

UnitedHealthcare develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting UnitedHealthcare's determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons through myuhc.com or the telephone number on the member's ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

Microtia: The most complex congenital ear deformity when the outer ear appears as either a sausage-shaped structure resembling little more than the earlobe. It may or may not be missing the external auditory or hearing canal. Hearing is impaired to varying degrees.

Reconstructive Procedures: Reconstructive Procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive Procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

Reconstructive Surgery: Defined by the American Society of Plastic Surgeons, "is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance."

Sickness: Physical illness, disease or Pregnancy. The term Sickness includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

CPT/HCPCS Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
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**

CPT/HCPCS Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
*11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
15570	Formation of direct or tubed pedicle, with or without transfer; trunk
15572	**Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs**
15574	**Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet**
15730	Midface flap (i.e., zygomaticofacial flap) with preservation of vascular pedicle(s)
15731	Forehead flap with preservation of vascular pedicle (e.g., axial pattern flap, paramedian forehead flap)
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (i.e., buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk
15736	Muscle, myocutaneous, or fasciocutaneous flap; upper extremity
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity

CPT/HCPCS Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
15740	Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel
15756	Free muscle or myocutaneous flap with microvascular anastomosis
15769	**Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)**
15771	**Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate** **Note: See also the Breast Reconstruction (for Louisiana Only) Medical Policy.**
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)** **Note: See also the Breast Reconstruction (for Louisiana Only) Medical Policy**
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
15773[LJL1]	**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[LJL2]	**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)**
19316	Mastopexy
~~19324~~	~~Mammaplasty, augmentation; without prosthetic implant~~
19325	~~Mammaplasty,~~**Breast** augmentation~~;~~ with ~~prosthetic~~ implant
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21181	Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial

CPT/HCPCS Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (e.g., micro-ophthalmia)
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach
21275	Secondary revision of orbitocraniofacial reconstruction
21295	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach

CPT/HCPCS Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
21296	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach
21299	Unlisted craniofacial and maxillofacial procedure
28344	Reconstruction, toe(s); polydactyly
30540	Repair choanal atresia; intranasal
30545	Repair choanal atresia; transpalatine
30560	Lysis intranasal synechia
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)
***L8600**	**Implantable breast prosthesis, silicone or equal**
***L8607**	**Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies**
***Q2026**	**Injection, Radiesse, 0.1 ml**
***Q2028**	**Injection, sculptra, 0.5 mg**
~~36468~~	~~Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk~~
~~67912~~	~~Correction of lagophthalmos, with implantation of upper eyelid lid load (e.g., gold weight)~~
The following codes are considered cosmetic; the codes do not improve a functional, physical or physiological impairment.	
*11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
*11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
*11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
*11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
*15775	Punch graft for hair transplant; 1 to 15 punch grafts
*15776	Punch graft for hair transplant; more than 15 punch grafts
*15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
*15781	Dermabrasion; segmental, face
*15782	Dermabrasion; regional, other than face
*15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
*15786	Abrasion; single lesion (e.g., keratosis, scar)
*15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
*15788	Chemical peel, facial; epidermal
*15789	Chemical peel, facial; dermal
*15792	Chemical peel, nonfacial; epidermal

CPT/HCPCS Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
*15793	Chemical peel, nonfacial; dermal
*15819	Cervicoplasty
*15824	Rhytidectomy; forehead
*15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, p-flap)
*15826	Rhytidectomy; glabellar frown lines
*15828	Rhytidectomy; cheek, chin, and neck
*15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
*17380	Electrolysis epilation, each 30 minutes
21270	**Malar augmentation, prosthetic material**
***69090**	**Ear piercing**
69300	**Otoplasty, protruding ear, with or without size reduction**
***J0591**	**Injection, deoxycholic acid, 1 mg**

~~CPT Code~~	~~Description~~
~~**The following codes are considered cosmetic; the codes do not improve a functional, physical or physiological impairment.**~~	
~~21270~~	~~Malar augmentation, prosthetic material~~
~~69090~~	~~Ear piercing~~
~~69300~~	~~Otoplasty, protruding ear, with or without size reduction~~

Codes labeled with an asterisk(*) are not on the state of Louisiana Fee Schedule and therefore not covered by the State of Louisiana Medicaid Program.

Coding Clarification

Flaps (Skin and/or Deep Tissues) Procedures: 15570-15738

- Codes 15733-15738 are described by donor site of the muscle, myocutaneous, or fasciocutaneous flap.
- A repair of a donor site requiring a skin graft or local flaps is considered an additional separate procedure.
  - For microvascular flaps, see 15756-15758.
  - For flaps without inclusion of a vascular pedicle, see 15570-15576.
  - For adjacent tissue transfer flaps, see instruction for 14000-14302 below.
- The regions listed refer to the recipient area (not the donor site) when a flap is being attached in a transfer or to a final site.
- Codes 15570-15738 do not include extensive immobilization (e.g., large plaster casts and other immobilizing devices are considered additional separate procedures).

Other Flaps and Grafts Procedures: 15740-15777

- Neurovascular pedicle procedures are reported with 15750. This code includes not only skin but also a functional motor or sensory nerve(s). The flap serves to reinnervate a

damaged portion of the body dependent on touch or movement (e.g., thumb). Repair of donor site requiring skin graft or local flaps should be reported as an additional procedure.

- Code 15740 describes a cutaneous flap, transposed into a nearby but not immediately adjacent defect, with a pedicle that incorporates an anatomically named axial vessel into its design. The flap is typically transferred through a tunnel underneath the skin and sutured into its new position. The donor site is closed directly.
- For random island flaps, V-Y subcutaneous flaps, advancement flaps, and other flaps from adjacent areas without clearly defined anatomically named axial vessels, see instruction for 14000-14302 below.

CPT Coding Tips

- For codes 15570, 15734, 15736, 15738 and 15740, ~~please~~ refer to the following CPT assistant monthly newsletter for additional coding guidelines for flap procedures:
  - MAR 10:4
  - MAR 13:13
  - MAR 04:11
  - APRIL 10:3
  - APR 14:10
  - SEP 03:15
  - SEP 04:12
  - OCT 04:15
  - OCT 13:15
  - NOV 02:7
  - DEC 12:6
- For codes 14000-14302, ~~please~~ refer to the following CPT assistant monthly newsletter for additional coding guidelines for adjacent tissue transfer or rearrangement:
  - JAN 06:47
  - JAN 12:8
  - MAR 10:4
  - APR 10:3
  - APR 14:10
  - MAY 12:13
  - JUL 00:10
  - JUL 08:5
  - JUL 99:3
  - AUG 96:8
  - AUG 12:13
  - SEP 96:11
  - NOV 12:13
  - DEC 12:6
  - DEC 06:15

~~HCPCS Code~~	~~Description~~
~~L8600~~	~~Implantable breast prosthesis, silicone or equal~~
~~L8607~~	~~Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies~~
~~Q2026~~	~~Injection, Radiesse, 0.1ml~~
~~Q2028~~	~~Injection, sculptra, 0.5 mg~~

Description of Services

Reconstructive procedures treat a physical and/or physiological abnormality related to an injury, illness, development abnormality, or Congenital Anomaly to improve or restore physiologic function. Whereas cosmetic procedures are performed to change or improve appearance without improving physiological function.

Autologous Fat Transfer

According to Bellini (2017), subcutaneous adipose tissue has been identified as an ideal filler for correcting and remodeling profile and volume body defects. This fatty tissue has been reported to contain a high percentage of adult stem cells. The standard fat grafting technique includes harvesting the tissue from a suitable donor site, processing the lipoaspirate to eliminate contaminants, followed by fat reimplantation. Patients with volume loss or contour deformities caused by disease, trauma, congenital defects, tumor extirpation or the natural aging process have considered fat grafting for reconstructive or cosmetic purposes. Common cosmetic procedures for fat grafting include recontouring the aging face (facial filler), lip augmentation, or buttock augmentation,.

Dermabrasion

Dermabrasion is a form of skin resurfacing used to treat less that optimal skin appearance such as sun damage, trauma, acne scarring, or age spots or wrinkles. This form of resurfacing or surgical scraping mechanically alters the skin at the level of the dermis to promote new skin growth and may be taken down layer by layer to remove the proper level of skin to obtain the desired effect. The technique leads to improvements in the skin appearance, quality, and structure (Smith, 2014).

Hair Procedures

Hair transplantation is a surgical option for hair loss. This procedure removes hair follicles from one part of the body to another part body. Androgenic alopecia is one of the common types of hair loss. This may occur in men or women.

Treatment options for excessive hair growth may include pharmacologic agents and/or hair removal. Hirsutism is excessive hair growth in women with a typical male pattern distribution. Causes may include polycystic ovary syndrome (PCOS) and idiopathic hyperandrogenism.

Liposuction for Undesirable Fat Deposits

Liposuction is performed to slim and reshape specific areas of the body by removing excess fat deposits to improve body contour and proportion in areas such as the abdomen, arms, buttocks, hips, thighs, or waist. The procedure can be performed alone or with other plastic surgery procedures such as a tummy tuck, breast reduction or a facelift (ASPS, 2022).

Keloids/Scars

Keloids and hypertrophic scars are caused by an excessive tissue response to dermal injury. Keloids are fibrous growths that extend beyond the original area of injury involving the adjacent normal skin. Hypertrophic scars may be similar in appearance but remain confined within the boundaries of the wounded area. Both may cause cosmetic disfigurement and/or functional impairment. Treatment for symptomatic keloids and hypertrophic scars may include conservative treatment such as intralesional

corticosteroids or compression as well as cryotherapy or surgical excision (Goldstein, 2021).

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Many cosmetic and reconstructive interventions are surgical procedures and are not subject to FDA approval. However, devices and instruments used during the procedures may require FDA approval. See the following website for additional information: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed April 1, 2022)

References

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Policy History/Revision Information

Date	Summary of Changes

TBD	**Template Update** • Changed policy type classification from "Coverage Determination Guideline" to "Medical Policy" **Coverage Rationale** • Removed language indicating some states require benefit coverage for services that UnitedHealthcare considers Cosmetic Procedures, such as repair of external Congenital Anomalies in the absence of a Functional Impairment ***Reconstructive Procedures*** • Replaced language indicating: ○ "*For plans that include benefits for Cosmetic Procedures, the [listed procedures] are eligible for coverage as* Reconstructive and medically necessary when all of the [listed] criteria are met" with "*a procedure is considered* Reconstructive and Medically Necessary when all of the [listed] criteria are met" ○ "Microtia repair is reconstructive; although no Functional Impairment may be documented for Microtia, *this has been deemed Reconstructive Surgery*" with "Microtia repair is *considered* Reconstructive although no Functional Impairment may be documented" • Added language to indicate flap repair is considered reconstructive and medically necessary in certain circumstances; for medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Tissue Transfer (Flap) ***Cosmetic Procedures*** • Replaced language indicating "*UnitedHealthcare excludes Cosmetic Procedures from coverage* including, but not limited to, the [listed procedures]" with "*the [listed] procedures are considered cosmetic and not Medically Necessary* including, but not limited to, the [listed procedures]" • Revised list of cosmetic and not medically necessary procedures: ○ Added: ▪ Autologous fat transfer when performed as a Cosmetic Procedure ▪ Revision of keloids when performed as a Cosmetic Procedure ○ Replaced: ▪ "Pharmacological regimens, nutritional procedures, or treatments" with "*cosmetic* pharmacological regimens, nutritional procedures, or *nutritional* treatments ▪ "Skin abrasion *procedures performed as* a treatment for acne and scar or tattoo removal *or revision procedures (such as salabrasion, chemosurgery*, and other such skin abrasion procedures)" with "skin abrasion for the treatment of scars or tattoo removal or acne and other such skin abrasion procedures" ▪ "Hair removal or replacement by any means" with "hair removal or replacement by any means, *except for hair removal as part of genital reconstruction prescribed by a physician for the treatment of gender dysphoria; for laser or electrolysis hair removal (CPT codes 17380 and 17999) in advance of genital reconstruction, refer to the Medical Policy titled Gender Dysphoria Treatment (for New Jersey Only)"* ○ Removed "treatment for spider veins"

Date	Summary of Changes
	Definitions • Added definition of "Medical Necessary" **Applicable Codes** • Updated list of CPT codes that may be cosmetic (review is required to determine if considered cosmetic or reconstructive): ○ Added 11921, 15572, 15574, 15769, 15771, 15772, 15773, 15774, 21270, 69090, and 69300 ○ Removed 19324, 36468, and 67912 ○ Revised description for 19325 • Updated list of CPT codes that are considered cosmetic (the codes do not improve a functional, physical, or physiological impairment); removed 21270, 69090, and 69300 • Added notation to indicate the following CPT/HCPCS codes 11922, 11950, 11951, 11952, 11954, 15775, 15776, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15819, 15824, 15825, 15826, 15828, 15829, 17380, 69090, J0591, L8600, L8607, Q2026, and Q2028 are not on the state of Louisiana Fee Schedule and therefore not covered by the State of Louisiana Medicaid Program **Supporting Information** • Added *Description of Services* and *FDA* sections • Updated *References* section to reflect the most current information • Archived previous policy version CS027LA.M

Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this guideline, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Coverage Determination Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.