

Cosmetic and Reconstructive Procedures

Guideline Number: CS027.X
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[Instructions for Use](#)

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| <ul style="list-style-type: none"> • Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair • Breast Reconstruction Post Mastectomy and Poland Syndrome • Breast Reduction Surgery • Breast Repair/Reconstruction Not Following Mastectomy • Gender Dysphoria Treatment • Omnibus Codes • Orthognathic (Jaw) Surgery • Panniculectomy and Body Contouring Procedures • Pectus Deformity Repair • Plagiocephaly and Craniosynostosis Treatment • Rhinoplasty and Other Nasal Surgeries • Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins |
| Commercial Policy |
| <ul style="list-style-type: none"> • Cosmetic and Reconstructive Procedures |

Application

This Coverage Determination Guideline does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

State	Policy/Guideline
Indiana	Cosmetic and Reconstructive Procedures (for Indiana Only)
Kentucky	Cosmetic and Reconstructive Procedures (for Kentucky Only)
Louisiana	Cosmetic and Reconstructive Procedures (for Louisiana Only)
Mississippi	Cosmetic and Reconstructive Procedures (for Mississippi Only)
Nebraska	Cosmetic and Reconstructive Procedures (for Nebraska Only)
New Jersey	Cosmetic and Reconstructive Procedures (for New Jersey Only)
North Carolina	Cosmetic and Reconstructive Procedures (for North Carolina Only)
Pennsylvania	Cosmetic and Reconstructive Procedures (for Pennsylvania Only)
Tennessee	Cosmetic and Reconstructive Procedures (for Tennessee Only)

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 for Coverage

For plans that include benefits for Cosmetic Procedures, the following are eligible for coverage as reconstructive and medically 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

[Microtia](#) repair is 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.

Sclerotherapy Treatment of Veins

- Cosmetic sclerotherapy is excluded.
- Sclerotherapy up to 3 sessions per leg within a year is covered. More than 3 sessions per leg within a year is considered cosmetic.
- A session is defined as one date of service in which sclerotherapy (36470, 36471) is performed.
- A year is defined as a rolling 12 months (365 days).

Documentation Requirements

Muscle Flap Procedure

Medical notes documenting the following, when applicable:

- History of medical conditions requiring treatment or surgical intervention which includes all of the following:
 - A well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment
 - Recurrent or persistent functional deficit caused by the abnormality
- Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment
- Color photos, where applicable, of the physical and/or physiological abnormality
- Physician plan of care with proposed procedures including expected outcome

All Other Cosmetic Procedures

Medical notes documenting the following, when applicable:

- History of medical conditions requiring treatment or surgical invention which includes all of the following:
 - To prove medical necessity, a well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment
 - Recurrent or persistent functional impairment caused by the abnormality
- Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment
- High-quality color image(s) of the physical/physiologic abnormality :
 - Note: All images must be labeled with the:
 - Date taken

- Applicable case number obtained at time of notification, or the member's name and ID number on the photograph(s)
 - Submission of color image(s) are required and can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted
- Physician plan of care with proposed procedures and whether this request is part of a staged procedure; indicate how the procedure will improve and/or restore function

Coverage Limitations and Exclusions

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 [Indications for Coverage](#) section
- Pharmacological regimens, nutritional procedures or treatments
- 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
- Sclerotherapy treatment of veins for cosmetic indications
- 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 (17380, 17999) in advance of genital reconstruction refer to the Medical Policy titled [Gender Dysphoria Treatment](#).)

Definitions

Check the definitions within the 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.

Microtia: The most complex congenital ear deformity when the outer ear appears as 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 Guidelines may apply.

CPT 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
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

CPT Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
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
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 Post Mastectomy and Poland Syndrome Coverage Determination Guideline.
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)
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19316	Mastopexy
19325	Breast augmentation with 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
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

CPT Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
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
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)
The following code for treatment for spider veins is considered cosmetic; does not improve a functional, physical or physiological impairment.	
36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk
The following codes are covered for sclerotherapy up to 3 sessions per leg within a year.	
<ul style="list-style-type: none"> • More than 3 sessions per leg within a year is considered cosmetic; do not improve a functional, physical or physiological impairment. (2019 Certificate of Coverage Amendment) Cosmetic sclerotherapy is excluded. • A session is defined as one date of service in which sclerotherapy (36470, 36471) is performed. • A year is defined as a rolling 12 months (365 days). 	
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg

CPT Code	Description
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
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 (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
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

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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, refer to the following CPT assistant monthly newsletter for additional coding guidelines for flap procedures:

○ MAR 10:4	○ APR 14:10	○ OCT 13:15
○ MAR 13:13	○ SEP 03:15	○ NOV 02:7
○ MAR 04:11	○ SEP 04:12	○ DEC 12:6
○ APRIL 10:3	○ OCT 04:15	
- For codes 14000–14302, refer to the following CPT assistant monthly newsletter for additional coding guidelines for adjacent tissue transfer or rearrangement:

○ JAN 06:47	○ MAY 12:13	○ AUG 12:13
○ JAN 12:8	○ JUL 00:10	○ SEP 96:11
○ MAR 10:4	○ JUL 08:5	○ NOV 12:13
○ APR 10:3	○ JUL 99:3	○ DEC 12:6
○ APR 14:10	○ AUG 96:8	○ DEC 06:15

HCPCS Code	Description
The following code is considered cosmetic; the code does not improve a functional, physical or physiological impairment.	
J0591	Injection, deoxycholic acid, 1 mg
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
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

References

American Medical Association (AMA). CPT® Assistant Online. Available at: <https://www.ama-assn.org/practice-management/cpt>. Accessed October 26, 2021.

American Society of Plastic Surgeons (ASPS) available at: <http://www.plasticsurgery.org/>. Accessed October 26, 2021.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2018.

Guideline History/Revision Information

Date	Summary of Changes
06/01/2022	<p>Coverage Rationale</p> <ul style="list-style-type: none"> • Removed reference to specific InterQual® release date; refer to the most current InterQual® criteria <p>Supporting Information</p> <ul style="list-style-type: none"> • Archived previous policy version CS027.W

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.