

# Cosmetic and Reconstructive Procedures (for Nebraska Only)

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**Effective Date:** April 1, 2025

[Instructions for Use](#)

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## Related Policies

- [Breast Reconstruction \(for Nebraska Only\)](#)
- [Breast Reduction Surgery](#)
- [Brow Ptosis and Eyelid Repair](#)
- [Omnibus Codes \(for Nebraska Only\)](#)
- [Orthognathic \(Jaw\) Surgery \(for Nebraska Only\)](#)
- [Panniculectomy and Body Contouring Procedures \(for Nebraska Only\)](#)
- [Plagiocephaly and Craniosynostosis Treatment](#)
- [Rhinoplasty and Other Nasal Procedures \(for Nebraska Only\)](#)
- [Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins](#)
- [Treatment of Temporomandibular Joint Disorders \(for Nebraska Only\)](#)

## Application

This Medical Policy only applies to the state of Nebraska.

## Coverage Rationale

### State-Specific Criteria

For medical necessity clinical coverage criteria for cosmetic and Reconstructive procedures, refer to the [Nebraska Department of Health and Human Services, Code 471-18: Physicians Services](#).

### Non State-Specific Criteria

#### Tissue Transfer (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.](#)

## Definitions

Refer to the federal, state, and contractual requirements that supersede the definitions below.

**Reconstructive Surgery:** 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 (COC, 2018).

## 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/HCPCS Code	Description
<b>The following codes may be cosmetic; review is required to determine if considered cosmetic or Reconstructive.</b>	
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
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)

CPT/HCPCS Code	Description
<b>The following codes may be cosmetic; review is required to determine if considered cosmetic or Reconstructive.</b>	
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate <b>Note:</b> Refer also to the Medical Policy titled <a href="#">Breast Reconstruction (for Nebraska Only)</a> .
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) <b>Note:</b> Refer also to the Medical Policy titled <a href="#">Breast Reconstruction (for Nebraska Only)</a> .
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)
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
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

CPT/HCPCS Code	Description
<b>The following codes may be cosmetic; review is required to determine if considered cosmetic or Reconstructive.</b>	
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
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
<b>The following codes are considered cosmetic; the codes do not improve a functional, physical, or physiological impairment.</b>	
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
15793	Chemical peel, nonfacial; dermal

CPT/HCPCS Code	Description
<b>The following codes are considered cosmetic; the codes do not improve a functional, physical, or physiological impairment.</b>	
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

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## 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 reshape or enhance appearance without improving physiological function (ASPS, 2023).

## 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. Refer to the following website for additional information: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed January 16, 2024)

## References

Nebraska Department of Health and Human Services. Nebraska Medical Assistance Program Services. Chapter 1, Administration. [Chapter-01.pdf \(nebraska.gov\)](#). Accessed May 1, 2024.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2018.

## Policy History/Revision Information

Date	Summary of Changes
07/01/2025	<b>Related Policies</b> <ul style="list-style-type: none"> <li>Removed reference link to the Medical Policy titled <i>Pectus Deformity Repair</i> (retired Jul. 1, 2025)</li> </ul>
04/01/2025	<b>Applicable Codes</b> <ul style="list-style-type: none"> <li>Updated list of applicable CPT codes to reflect annual edits; removed 15819</li> </ul> <b>Supporting Information</b> <ul style="list-style-type: none"> <li>Archived previous policy version CS027NE.R</li> </ul>

## Instructions for Use

This Medical Policy 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 policy, 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 Medical Policy 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 Medical Policies 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.