

# Cosmetic, Reconstructive, or Plastic Surgery

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[➔ Instructions for Use](#)

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## Related Benefit Interpretation Policies

- [Dental Care and Oral Surgery](#)
- [Gender Dysphoria \(Gender Identity Disorder\) Treatment](#)
- [Medical Necessity](#)
- [Post Mastectomy Surgery](#)

## Related Medical Management Guidelines

- [Blepharoplasty, Blepharoptosis and Brow Ptosis Repair](#)
- [Breast Reconstruction Post Mastectomy and Poland Syndrome](#)
- [Breast Reduction Surgery](#)
- [Breast Repair/Reconstruction Not Following Mastectomy](#)
- [Cosmetic and Reconstructive Procedures](#)
- [Gynecomastia Treatment](#)
- [Orthognathic \(Jaw\) Surgery](#)
- [Panniculectomy and Body Contouring Procedures](#)
- [Pectus Deformity Repair](#)
- [Rhinoplasty and Other Nasal Surgery](#)

## Federal/State Mandated Regulations

### Women's Health and Cancer Rights Act of 1998, § 713 (a)

[https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra\\_factsheet](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet)

"In general, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- (1) For all stages of reconstruction of the breast on which the mastectomy has been performed;
- (2) Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- (3) Prostheses and physical complications, all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient."

### California Health & Safety Code §1367.63

[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=1367.63&lawCode=HSC](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.63&lawCode=HSC)

- a. Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, renewed, or delivered in this state on or after July 1, 1999, shall cover reconstructive surgery, as defined in subdivision (c)

- that is necessary to achieve the purposes specified in subparagraph (A) or (B) of subdivision (c). Nothing in this section shall be construed to require a plan to provide coverage for cosmetic surgery, as defined in subdivision (d).
- b. No individual, other than a licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment pursuant to this section. For a treatment authorization request submitted by a podiatrist or an oral and maxillofacial surgeon, the request may be reviewed by a similarly licensed individual competent to evaluate the specific clinical issues involved in the care requested.
  - c.
    - (1) "Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
      - (A) To improve function.
      - (B) To create a normal appearance, to the extent possible.
    - (2) As of July 1, 2010, "reconstructive surgery" shall include medically necessary dental or orthodontic services that are an integral part of reconstructive surgery, as defined in paragraph (1), for cleft palate procedures.
    - (3) For purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate
  - d. "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.
  - e. In interpreting the definition of reconstructive surgery, a health care service plan may utilize prior authorization and utilization review that may include, but need not be limited to, any of the following:
    - 1) Denial of the proposed surgery if there is another more appropriate surgical procedure that will be approved for the enrollee.
    - 2) Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, offer only a minimal improvement in the appearance of the enrollee.
    - 3) Denial of payment for procedures performed without prior authorization.
    - 4) For services provided under the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), denial of the proposed surgery if the procedure offers only a minimal improvement in the appearance of the enrollee, as may be defined in any regulations that may be promulgated by the State Department of Health Care Services.
  - f. As applied to services described in paragraph (2) of subdivision (c) only, this section shall not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code, where such contracts do not provide coverage for California Children's Services (CCS) or dental services.

## State Market Plan Enhancements

Members may have benefits for Transgender Reassignment Surgery (a sex change). Refer to the Benefit Interpretation Policy titled [Gender Dysphoria \(Gender Identity Disorder\) Treatment](#).

Medically necessary reduction mammoplasty is a covered benefit when medical criteria are met and approved and authorized by the participating PMG/IPA or UnitedHealthcare Medical Director. Reviews are based on both of the following:

- The American Society of Plastic Surgeon's (ASPS) Recommended Insurance Coverage Criteria for Third Party Payers: <http://www.plasticsurgery.org/about-asps.html>
- Photographs

## Covered Benefits

**Important Note:** Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Note: Reconstructive and Cosmetic procedures require preauthorization by the Member's Primary Care Physician, Medical Group or UnitedHealthcare in agreement with the standards of care as practiced by Physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.

Reconstructive Surgery when needed to correct or repair abnormal structures of the body caused by Congenital Defects, developmental abnormalities, trauma, infection, tumors or disease (including medically necessary dental or orthodontic services that are an integral part of the reconstructive surgery for Cleft Palate procedures) to improve function or create a normal appearance to the extent possible. Refer to *Federal/State Mandated Regulations, State Market Plan Enhancements* sections.

- In determining coverage for Reconstructive Procedures that are not intended to improve function, but which are designed only “To create a normal appearance to the extent possible”, relevant factors to consider include:
  - Member’s prior appearance
  - Ethnicity
  - Body habitus (general appearance)
  - Age (changes consistent with aging are considered normal)
  - Bilaterality (comparison to the contralateral side)
  - The degree of deviation from the generally-accepted range of normal, taking into consideration reasonable expectations of surgical outcome, based upon professional medical judgement and physician review of clinical photographs, where appropriate
- Examples include, but are not limited to:
  - Release of scar contracture
  - Breast reduction surgery (mammoplasty) based on medical necessity. Refer to *State Market Plan Enhancements* section. Refer to the Medical Management Guideline titled [Breast Reduction Surgery](#).
  - Treatment of Gynecomastia. Refer to the Medical Management Guideline titled [Gynecomastia Treatment](#).
  - Surgery to correct hypospadias
- Examples of covered Reconstructive Surgeries or treatments that would be performed to correct abnormal conditions caused by Congenital Defects, developmental abnormalities, trauma, infection, tumors or disease include, but are not limited to:
  - Release of scar contracture
  - Surgical correction of microtia (ear absence or deformity)
  - Breast reconstruction due to congenital absence of a breast. Refer to the Medical Management Guideline titled [Breast Reconstruction Post Mastectomy and Poland Syndrome](#)
  - Breast reconstruction to correct breast asymmetry. Refer to the Medical Management Guidelines titled [Breast Reconstruction Post Mastectomy and Poland Syndrome](#) and [Breast Repair/Reconstruction Not Following Mastectomy](#)
  - Surgical treatment of polydactyl (extra fingers, toes)
  - Surgical correction of gynecomastia; Refer to the Medical Management Guideline titled [Gynecomastia Treatment](#)
  - Surgical correction of hypospadias
  - Reconstruction of the jaw after the removal of tumor or cancer. Refer to the Medical Management Guideline titled [Orthognathic \(Jaw\) Surgery](#)
  - Repair of Cleft Palate and Cleft lip Refer to the Medical Management Guideline titled [Orthognathic \(Jaw\) Surgery](#)
  - Multi-stage Reconstructive Procedures that are part of an authorized treatment plan e.g. removal of a large hemangioma, removal of port wine stain, breast reconstruction, scar revisions
  - Blepharoplasty for:
    - Traumatic eye injury (e.g., orbital roof fracture) or
    - Neurological ptosis (e.g. myasthenia gravis, third nerve paresis, and Horner syndrome (unilateral pupillary abnormality with ptosis caused by sympathetic nerve damage)) or
    - Ectropion (outward turning of the upper or lower eyelid) or
    - Entropion (inward turning of upper or lower eyelid)
    - Brow lift. Refer to the Medical Management Guideline titled [Blepharoplasty, Blepharoptosis and Brow Ptosis Repair](#)

Reconstructive Surgery requests may be approved if the surgery either meets the criteria for coverage under *Federal/State Mandated Regulations* section or meets the criteria for medical necessity.

If the above criteria are not met, a surgical procedure may still be covered when medical necessity criteria for the surgery are met.

Examples of conditions and procedures that may be covered when medical necessity criteria are met (refer to the Benefit Interpretation Policy titled [Medical Necessity](#)):

- Breast reduction surgery (mammoplasty). Refer to the Medical Management Guideline titled [Breast Reduction Surgery](#)
- Panniculectomy; Refer to the Medical Management Guideline titled [Panniculectomy and Body Contouring Procedures](#)
- Repair of ptosis (drooping of the eyelids). Refer to the Medical Management Guideline titled [Blepharoplasty, Blepharoptosis and Brow Ptosis Repair](#)
- Blepharoplasty Refer to the Medical Management Guideline titled [Blepharoplasty, Blepharoptosis and Brow Ptosis Repair](#)

## Not Covered

- Reconstructive Surgeries are not covered when there is another more appropriate surgical procedure that has been offered to the member as determined or defined by UnitedHealthcare or designee or when only minimal improvement in the member's appearance is expected to be achieved.
- Non-medically necessary Cosmetic, Elective or voluntary Enhancement Procedures or Services, supplies and medications. Examples include, but are not limited to:
  - Surgical Procedures to correct consequences of normal aging
  - Surgical Procedures to remove common, benign skin lesions not caused by Congenital Defects, developmental abnormalities, trauma, infection, tumors, or disease
  - Services related to hereditary pattern baldness, sexual performance, athletic performance, Cosmetic purposes, anti-aging, and mental performance
  - Tattoo removal, dermabrasion or liposuction

## Definitions

**Cleft Palate:** A condition that may include a Cleft Palate, Cleft lip, or other craniofacial anomalies related with a Cleft Palate.

**Congenital Defect:** A condition present at birth.

**Cosmetic Services and Surgery:** Cosmetic Surgery and Cosmetic Services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Member's dissatisfaction with his or her appearance.

**Elective Enhancements:** Procedures, technologies, services, drugs, devices, items and supplies for Elective non-medically necessary, improvements, alterations, or Enhancements, or augmentation of appearance, skills, performance capability, physical or mental attributes, or competencies are not covered. This exclusion includes, but is not limited to, Elective improvements, alterations, Enhancements, augmentation, or genetic manipulation related to aging, athletic performance, intelligence, weight or Cosmetic appearance.

**Reconstructive Surgery:** Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to improve function or create a normal appearance to the extent possible.

## Policy History/Revision Information

Date	Summary of Changes
01/01/2022	<ul style="list-style-type: none"><li>• Routine review; no change to benefit coverage guidelines</li><li>• Archived previous policy version BIP169.J</li></ul>

## Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage,

limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.