

COSMETIC AND RECONSTRUCTIVE PROCEDURES

Guideline Number: MMG029.L

Effective Date: August 1, 2019

[Instructions for Use](#) ⓘ

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Related Medical Management Guidelines

- [Blepharoplasty, Blepharoptosis and Brow Ptosis Repair](#)
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- [Breast Reduction Surgery](#)
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- [Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins](#)

Related Benefit Interpretation Policy

- Cosmetic, Reconstructive, or Plastic Surgery

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. Please refer to the member specific benefit plan document.

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/medically necessary 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

Coverage Limitations and Exclusions

UnitedHealthcare West 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
- Procedure 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 (**Note:** *Sclerotherapy in excess of 3 sessions per leg is considered cosmetic*).
- Hair removal or replacement by any means.

DOCUMENTATION REQUIREMENTS

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

Required Clinical Information

Muscle Flap Procedures

Medical notes documenting **all** of the following:

- 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 **all** of the following:

- 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 photograph(s); all photos must be labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s)

Note: Submission of color photos are required and can be submitted via the external portal at www.uhcprovider.com/paan or via email at CCR@uhc.com; faxes of color photos 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

DEFINITIONS

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

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 Defect: A physical developmental defect that is present at birth.

Cosmetic Services and Surgery (California only): Cosmetic surgery and cosmetic services are not covered. 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. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. 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.

Cosmetic Services and Surgery (OK, OR, TX and WA only): Cosmetic surgery and cosmetic services are not covered. 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. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. 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, as influenced by that Member's underlying psychological makeup or psychiatric condition.

Functional or Physical Impairment: A physical or functional 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 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 Surgery: Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible.

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 guideline 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 the member specific benefit plan document 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
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
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)

CPT Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
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
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19316	Mastopexy
19324	Mammoplasty, augmentation; without prosthetic implant
19325	Mammoplasty, 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
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

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

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
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 for sclerotherapy in excess of 3 sessions are considered cosmetic; do not improve a functional, physical or physiological impairment:	
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg

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Coding Clarification

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

- Codes 15732–15738 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, 15732, 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

REFERENCES

American Medical Association (AMA); CPT® Assistant Online; 2014; Available at: <http://www.ama-assn.org/ama> Accessed April 15, 2019

American Society of Plastic Surgeons (ASPS) available at: <http://www.plasticsurgery.org/> Accessed April 15, 2019

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
08/01/2019	<p>Template Update</p> <ul style="list-style-type: none"> • Updated/reorganized policy template: <ul style="list-style-type: none"> ○ Simplified and relocated <i>Instructions for Use</i> ○ Removed <i>Benefit Considerations</i> section ○ Added <i>Documentation Requirements</i> section <p>Coverage Rationale</p> <ul style="list-style-type: none"> • Added language to clarify the [listed procedures] are <i>eligible for coverage as reconstructive and medically necessary for plans that include benefits for Cosmetic Procedures</i> when all of the [listed] criteria are met • Revised list of Cosmetic Procedures excluded from coverage; added: <ul style="list-style-type: none"> ○ 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 (Note: <i>Sclerotherapy in excess of 3 sessions per leg is considered cosmetic</i>) ○ Hair removal or replacement by any means <p>Definitions</p> <ul style="list-style-type: none"> • Updated definition of: <ul style="list-style-type: none"> ○ Congenital Defect ○ Reconstructive Surgery • Removed definition of: <ul style="list-style-type: none"> ○ Congenital Anomaly (California only) ○ Reconstructive Procedures (California only) <p>Applicable Codes</p> <ul style="list-style-type: none"> • CPT codes that may be cosmetic (review is required to determine if considered cosmetic or reconstructive): Removed and relocated 36468 • CPT codes that are considered cosmetic for treatment for spider veins (does not improve a functional, physical or physiological impairment): Added 36468 • CPT codes that are considered cosmetic for sclerotherapy in excess of 3 sessions

Date	Action/Description
	(does not improve a functional, physical or physiological impairment): Added 36470 and 36471 Supporting Information <ul style="list-style-type: none"> Archived previous policy version MMG029.K

INSTRUCTIONS FOR USE

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

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare West Medical Management 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.

Member benefit coverage and limitations may vary based on the member’s benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.