Cosmetic and Reconstructive Procedures

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Instructions for Use

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Application

UnitedHealthcare Commercial

This Medical Policy applies to all UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado.

Coverage Rationale

See Benefit Considerations

Reconstructive Procedures

A procedure is considered 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 individual's physiological function.

Note: Microtia repair is considered Reconstructive although no Functional Impairment may be documented.

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.

Cosmetic Procedures

Cosmetic procedures are procedures or services that change or improve appearance without significantly improving physiological function. A procedure is considered to be a cosmetic procedure when it does not meet the reconstructive criteria in the reconstructive procedures section above.

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.

Note: Refer to the Benefit Considerations section for additional information on cosmetic services and exclusions.

Definitions

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

Cosmetic Surgery: Cosmetic Surgery is performed to reshape normal structures of the body in order to enhance an individual's appearance and self-esteem (Freeman., 2023).

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.

Microtia: Microtia is a birth defect of a baby's ear. Microtia happens when the external ear is small and not formed properly. The defect can vary from being barely noticeable to being a major problem with how the ear forms. Usually, Microtia affects how the baby's ear looks, but the parts of the ear inside the head are not affected (CDC., 2023).

Reconstructive Surgery: Reconstructive Surgery is carried out on atypical structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. Reconstructive Surgery is commonly performed to restore function but may also be performed to approximate a normal appearance (Freeman., 2023).

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.

CPT/HCPCS Codes*	Required Clinical Information
Tissue Transfer (Flap) Procedures	
15730 15733 15734 15738	Medical notes documenting the following, when applicable: • History of medical conditions requiring treatment or surgical intervention, including: ○ A well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment

CPT/HCPCS Codes*	Required Clinical Information
Tissue Transfer (Flap) Procedures	
15740 15756	• 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 In addition to the above, additional documentation requirements may apply for the following codes. Review the below listed policies in conjunction with the guidelines in this document: • For CPT codes 15734 and 15738, refer to the Medical Policy titled Gender Dysphoria Treatment
Cosmetic and Reconstructive Procedures	

11960, 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 14301, 14302, 15570, 15572, 15574, 17999, 19316, 19325, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21181, 21182, 21183, 21184, 21208, 21209, 21230, 21235, 21248, 21249, 21255, 21256, 21260, 21261, 21263, 21267, 21268, 21275, 21295, 21296, 21299, 28344, 30540, 30545, 30560, 30620, L8600, Q2026	Medical notes documenting the following, when applicable:
	• History of medical conditions requiring treatment or surgical invention, including:
	  ○ 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 image(s) must be labeled with the:
	  ▪ Date taken
	  • Applicable case number obtained at time of notification, or member's name and ID number on the image(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
	
	In addition to the above, additional documentation requirements may apply for the following codes. Review the below listed policies in conjunction with the guidelines in this document:
	• For CPT codes 19316, 19325, and L8600, refer to the Medical Policy titled Breast Reconstruction.
	• For CPT codes 14000, 14001, 14041, 15734, and 15738, refer to the Medical Policy titled Gender Dysphoria Treatment.
	• For CPT codes 21208, 21209, 21248, 21249, 21255, 21296, and 21299, refer to the Medical Policy titled Orthognathic (Jaw) Surgery.
	• For CPT codes 14040, 14060, and 14301, refer to the Medical Policy titled Outpatient Surgical Procedures – Site of Service (for Commercial Only) or Outpatient Surgical Procedures – Site of Service (for Individual Exchange Only).

*For code descriptions, refer to the Applicable Codes section.

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 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/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
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)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate **Note**: Refer to the Medical Policy titled Breast Reconstruction.

CPT/HCPCS Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
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**: Refer to the Medical Policy titled Breast Reconstruction.
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
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)
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
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)

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

CPT/HCPCS Code	Description
The following codes are considered cosmetic; the codes do not improve a functional, physical, or physiological impairment.	
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
J0591	Injection, deoxycholic acid, 1 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. (ASPS, 2023)

Benefit Considerations

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. Refer to the member specific benefit plan document.

Cosmetic procedures are excluded from coverage.

In most benefit plans the following cosmetic procedures are specifically excluded from coverage:

- 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. This exclusion does not apply to reconstructive liposuction.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Sclerotherapy treatment of 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.(For laser or electrolysis hair removal in advance of genital reconstruction, refer to the Medical Policy titled Gender Dysphoria Treatment (for Commercial Only) or Gender Dysphoria Treatment (for Individual Exchange Only).

Additional Information

- Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*,

including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other covered health care service.
- If the original service was not a covered benefit under the contract or UnitedHealthcare guidelines, (e.g. cosmetic, investigational, not a covered health service, etc.), then benefits are limited to the treatment of the complication. Examples include, but are not limited to:
  - Removal of a leaking or defective silicone breast prosthesis is a covered health care service. However, benefits for replacement of the breast prosthesis are only available if the original prosthesis was considered "reconstructive."

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 March 16, 2023)

References

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UnitedHealthcare Insurance Company Generic Certificate of Coverage 2018.

Policy History/Revision Information

Date	Summary of Changes

03/01/2024	**Related Policies**
	• Updated reference link to reflect current policy title for:
	  ○ *Gender Dysphoria Treatment*
	  ○ *Treatment of Temporomandibular Joint Disorders*

10/01/2023	**Application** ***Individual Exchange Plans*** • Removed language indicating this Medical Policy does not apply to Individual Exchange benefit plans in the states of Massachusetts, Nevada, and New York **Supporting Information** • Archived previous policy version MP.007.26

Instructions for Use

This Medical Policy 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 plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, 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 Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. 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.