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| **Policy Number** | **SUR716.001** |
| **Policy Effective Date** | **01/01/2026** |

# Cosmetic and Reconstructive Procedures

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## Disclaimer

**Carefully check state regulations and/or the member contract.**
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

## Legislative Mandates

**EXCEPTION: For Illinois only**: Illinois Public Act 103-0123 (IL HB 1384) Coverage for Reconstructive Services requires the following policies amended, delivered, issued, or renewed on or after January 1, 2025 (Individual and family PPO/HMO/POS; Student; Group [Small Group; Mid-Market; Large Group Fully Insured PPO/HMO/POS] or Medicaid), to provide coverage for medically necessary services that are intended to restore physical appearance on structures of the body damaged by trauma.

EXCEPTION: For HCSC members residing in the state of Arkansas, § 23-79-1502 relating to craniofacial anomaly corrective surgery, requires coverage and benefits for reconstructive surgery and related medical care for a person of any age who is diagnosed as having a craniofacial anomaly if the surgery and treatment are medically necessary to improve a functional impairment that results from the craniofacial anomaly. Coverage shall also be required, annually, for Sclera contact lenses, including coatings, office visits, an ocular impression of each eye, and any additional tests or procedures that are medically necessary for a craniofacial patient. Coverage shall also be required every two [2] years, two [2] hearing aids and two [2] hearing aid molds for each ear; this includes behind the ear, in the ear, wearable bone conductions, surgically implanted bone conduction services, and cochlear implants. Medical care coverage required includes coverage for reconstructive surgery, dental care, and vision care. This applies to the following: Fully Insured Group, Student, Small Group, Mid-Market, Large Group,

HMO, EPO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

EXCEPTION: For HCSC members residing in the state of Arkansas, § 23-79-150 relating to musculoskeletal disorders of the face, neck, or head, requires coverage, when such coverage is elected by the group policyholder, for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and nonsurgical procedures. This coverage shall be provided for medically necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. This applies to the following: Fully Insured Group, Student, Small Group, Mid-Market, Large Group, HMO, EPO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

EXCEPTION: For HCSC members residing in the state of Arkansas, § 23-99-405 related to coverage of mastectomy and reconstruction services, should an enrollee elect reconstruction after a mastectomy, requires coverage for surgery and reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and protheses and coverage for physical complications at all stages of a mastectomy, including lymphedema. This applies to the following: Fully Insured Group, Student, Small Group, Mid-Market, Large Group, HMO, EPO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

**EXCEPTION:** For HCSC members residing in the state of Mississippi, §83-9-45 requires coverage for diagnostic and surgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage for diagnostic services and surgery shall be the same as that for treatment to any other joint in the body and shall apply if the treatment is administered or prescribed by a physician or dentist. This applies to the following: Fully Insured Group, Small Group, Mid-Market, Large Group, HMO, EPO, PPO, POS.

## Coverage

**This medical policy does NOT address Gender Reassignment Services (Transgender Services). This medical policy IS NOT TO BE USED for Gender Reassignment Services. Refer to SUR717.001, Gender Assignment Surgery and Gender Reassignment Surgery with Related Services**

**NOTE 1**: For coverage of specific procedures please see the specific medical policy where indicated.

**NOTE 2**: Determinations of whether a proposed therapy would be considered reconstructive or cosmetic should always be interpreted in the context of the specific contract benefits language. In general, the presence of a functional impairment would render its treatment medically necessary and thus not subject to contractual definitions of reconstructive or cosmetic.

**COSMETIC PROCEDURES**:

Services that are provided primarily to alter and/or enhance appearance in the absence of documented impairment of physical function **are considered to be cosmetic**.

The majority of contracts have exclusions for cosmetic services or supplies. The following table below indicates services that may be considered either cosmetic or reconstructive, depending on the diagnosis, and documentation of progressive functional impairment. This list is not intended to be all inclusive. Refer to the individual medical policy if indicated for a specific procedure.

Cosmetic procedures **would not be eligible for benefits** because of psychiatric, psychosocial or emotional issues.

**Special Comment Regarding Cosmetic Services:** Determination of benefit coverage for procedures considered to be cosmetic is based on how a member's contract defines cosmetic services and their eligibility for benefit coverage.

**RECONSTRUCTIVE PROCEDURES:**

Procedures are considered reconstructive and therefore **may be considered medically necessary when**:

- There is documented evidence of physical functional impairment; OR
- Services are provided primarily to correct documented progressive impairment of physical function that interferes with the performance of activities of daily living; OR
- The conditions of impairment must meet the definition of reconstructive services in the benefit contract of the member for whom a procedure is being considered.

Documentation for reconstructive surgery must include appropriate historical medical record documentation which may include any of the following:

- Photographs; and/or
- Consultation reports; and/or
- Operative reports and/or other applicable hospital records (examples: pathology report, history and physical); and/or
- Office records; and/or
- Letters with pertinent information from:
  1. Providers;
  2. Subscribers.

The plan requires medical records for determination of medical necessity. When medical records are requested, a letter of support and/or explanation may be helpful, but alone will not be considered sufficient documentation to make a medical necessity determination.

**Table 1: The following table contains a listing of cosmetic and reconstructive procedures, which include but are not limited to the following:**

| Clinical Conditions | Reconstructive | Cosmetic |
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| Abdominoplasty | Cosmetic for all indications. | Cosmetic for all indications. |
| Brow Lift and Brow Ptosis | Cosmetic for all indications. | Cosmetic for all indications. |
| Congenital Anomaly | Correction of a condition existing at birth, which is a significant deviation from common anatomical form.<br><br>CHECK CONTRACTS FOR COVERAGE ELIGIBILITY. | CHECK CONTRACTS FOR COVERAGE ELIGIBILITY. |
| Hair Transplant (Hairplasty) | Punch graft hair transplant may be considered reconstructive when it is performed for eyebrow(s) or symmetric hairline replacement following a burn injury, trauma or tumor removal.<br><br>CHECK CONTRACTS FOR COVERAGE ELIGIBILITY. | CHECK CONTRACTS FOR COVERAGE ELIGIBILITY. |
| Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) | Dermal injections for facial lipodystrophy syndrome (LDS) using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in human immunodeficiency virus (HIV)-infected individuals when LDS caused by antiretroviral HIV treatment is a significant contributor to their depression. | CHECK CONTRACTS FOR COVERAGE ELIGIBILITY. |
| Benign skin lesion removal (seborrheic keratoses, skin tags, milia, moluscum contagiosum, sebaceous (epidermoid) cysts, moles (nevi), acquired hyperkeratosis (keratoderma) and viral warts (excluding condyloma acuminatum) | One or more of the following conditions is present and clearly documented in the medical record:<br>A. The lesion has one or more of the following characteristics:<br>1. Bleeding<br>2. Intense itching<br>3. Pain<br>B. The lesion has physical evidence of inflammation, e.g., purulence, oozing, edema, erythema. | Removal of benign asymptomatic lesions |

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| (This section does not address routine foot care or treatment of other skin lesions, e.g., ulcers, abscess, malignancies, dermatoses or psoriasis) | C. The lesion obstructs an orifice or clinically restricts vision.<br>D. The clinical diagnosis is uncertain, particularly where malignancy is a realistic consideration based on lesional appearance (e.g., non-response to conventional treatment, or change in appearance).<br>E. A prior biopsy suggests or is indicative of lesion malignancy or premalignancy.<br>F. The lesion is in an anatomical region subject to recurrent physical trauma and there is documentation that such trauma has in fact occurred.<br>G. Wart removals will be covered under (a) through (f) above. In addition, wart destruction will be covered when the following clinical circumstance is present:<br>• Periocular warts associated with chronic recurrent conjunctivitis thought secondary to lesional virus shedding<br>• Evidence of spread from one body area to another, particularly in immunocompromised/ immunosuppressed individuals. | |
| Mentoplasty, Genioplasty or chin implant | See Medical Policy SUR717.001 Gender Assignment Surgery and Gender Reassignment Surgery with Related Services. | See also Medical Policy SUR717.001 Gender Assignment Surgery and Gender Reassignment Surgery with Related Services.<br><br>CHECK CONTRACTS FOR COVERAGE ELIGIBILITY. |

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| Otoplasty | • Ears are absent; or<br>• Deformed from trauma, neoplastic surgery, disease or congenital anomalies.<br><br>CHECK CONTRACTS FOR COVERAGE ELIGIBILITY. | CHECK CONTRACTS FOR COVERAGE ELIGIBILITY. |
| Panniculectomy | • Documentation that the panniculus causes chronic intertrigo [dermatitis occurring on apposed surfaces of the skin, skin irritation, infection or chafing that consistently recurs or remains refractory to appropriate medical therapy (e.g., topical antifungals, corticosteroids, antibiotics)] over a period of 3 months.<br><br>• Difficulty walking or functional impairment in activities of daily living due to pannus size, chronic pain, and/or ulceration created by the abdominal skin fold. Preoperative photographs may be required to support justification and should be supplied upon request.<br><br>CHECK CONTRACTS FOR COVERAGE ELIGIBILITY. | Cosmetic for all other indications. |
| Congenital Port Wine Stain, Hemangiomas, and Other External Vascular Malformations | Port wine stains, hemangiomas, and other external vascular malformations that have medical record documentation of progressive functional impairment. | Treatment performed primarily to alter or enhance appearance. |
| Rhytidectomy | Functional impairment as a result of a disease state e.g. facial paralysis. (often this procedure is | CHECK CONTRACTS FOR COVERAGE ELIGIBILITY. |

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| | performed in conjunction with other procedures to correct the impairment) | |
| Suction Assisted Lipectomy or body contouring with liposuction | Body contouring following surgery is an integral part of the procedure.<br><br>See Medical Policy SUR716.011 Reconstructive Breast Surgery.<br><br>See Medical Policy SUR701.024 Surgery for Lipedema and Lymphedema. | See also Medical Policy SUR716.011 Reconstructive Breast Surgery.<br><br>See also Medical Policy SUR708.003 Liposuction for Lipedema and Lymphedema.<br><br>Liposuction used for body contouring, weight reduction or the harvest of fat tissue for transfer to another body region for alteration of appearance or self-image or physical appearance.<br><br>CHECK CONTRACTS FOR COVERAGE ELIGIBILITY. |
| Tattoos | • For nipple/areola reconstruction following mastectomy.<br>• Reconstruction following trauma or removal of cancer from an eyelid, eyebrow or lips | CHECK CONTRACTS FOR COVERAGE ELIGIBILITY. |

## Policy Guidelines

None.

## Description

The coverage of medical and surgical procedures to treat anomalies of the musculoskeletal and of the integumentary systems (i.e., the skin, subcutaneous and accessory structures including

the breast) is often based on a determination of whether the anomalies is considered cosmetic or reconstructive in nature.

COSMETIC PROCEDURES are intended solely to improve appearance and self-esteem not to restore bodily function or correct deformity.

RECONSTRUCTIVE SURGERY restores form but does not always correct or restore bodily function. It is generally done to improve function but may also be done to approximate a normal appearance.

## Rationale

This policy is based on a review of coverage guidance from the Centers for Medicare and Medicaid Services (CMS) and professional society criteria.

## Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

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| **CPT Codes** | 11200, 11201, 11920, 11921, 11922, 11950, 11951, 11952, 11954, 11960, 11970, 15775, 15776, 15780, 15781, 15782, 15783, 15786, 15787, 15824, 15825, 15826, 15828, 15829, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 15876, 15877, 15878, 15879, 17380, 19318, 19355, 21120, 21121, 21122, 21123, 21282, 31573, 31574, 41872, 54660, 67900, 69090, 69300, 0419T, 0420T, 0479T, 0480T |
| **HCPCS Codes** | G0429, J3490, L8607, Q2026, Q2028 |

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

## References


1. Centers for Medicare and Medicaid Services. Local Coverage Determination for Cosmetic and Reconstructive Surgery (L39051) (October 13, 2024) (Revision 3). Available at <https://www.cms.gov> (accessed December 14, 2025).
2. Centers for Medicare and Medicaid Services. Local Coverage Determination for Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (L34233) (October 23, 2025) (Revision 10). Available at <https://www.cms.gov> (accessed December 14, 2025).

3. Centers for Medicare and Medicaid Services. Local Coverage Determination for Cosmetic and Reconstructive Surgery (L39506) (May 28, 2023) (Revision 0). Available at <https://www.cms.gov> (accessed December 14, 2025).
4. Centers for Medicare and Medicaid Services. National Coverage Determination Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) 250.5 (March 23, 2010) (Revision 0). Available at <https://www.cms.gov> (accessed December 14, 2025).
5. American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria: Panniculectomy July 2006 (re-approved March 2019). Available at <https://www.plasticsurgery.org> (accessed December 14, 2025).
6. American Society of Plastic Surgeons. ASPS Recommended Insurance Coverage Criteria: Ear Deformity: Prominent Ears December 2005 (reaffirmed: June 2015). Available at <https://www.plasticsurgery.org> (accessed December 14, 2025).
7. Krowchuk D, Frieden I, Mancini A, et al. Clinical practice guide for the management of infantile hemangiomas. Pediatrics. Jan 2019; 143(1):e20183475. PMID 30584062

## Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been changed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

## Policy History/Revision

| Date | Description of Change |
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| 01/01/2026 | Document updated. The following changes were made to the Coverage: 1) Table 1 significantly revised, 2) Table 2 removed. References added: 1-4 and 6-7; others removed. |
| 02/15/2025 | Document updated with literature review. The following changes were made to the Coverage: “congenital defects” or “congenital abnormalities” were replaced with “congenital anomalies” and added “(See information under Congenital Anomaly) to the following Clinical Conditions addressing Gingivoplasty, Otoplasty, Restoration of body form. No new references added. |
| 02/01/2024 | Document updated with literature review. The following changes were made to the Coverage: 1) Added Reconstructive and Cosmetic indications for Gingivoplasty; 2) Replaced the Cosmetic indication of over the age of 19 with CHECK CONTRACTS FOR COVERAGE ELIGIBILITY for Congenital Anomaly. Reference number 13 add, other references updated. |

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| 05/01/2023 | Document updated with literature review. The following changes were made to the Coverage: 1) Under Otoplasty in the reconstructive column - Added "neoplastic" to the following statement: Deformed from trauma, neoplastic surgery, disease or congenital defects; 2) Under Scar revision in the reconstructive column - Added "neoplastic" to the following statement: Resulting from trauma or neoplastic surgery. Documentation must show conservative treatment of the scar has failed; 3) Under Restoration of body form in the reconstructive column - Removed the following statement: Disfiguring or extensive scars resulting from neoplastic surgery. No new references added; some updated, one reference removed. |
| 01/15/2022 | Document updated with literature review. The following changes were made to Coverage: Separated abdominoplasty/panniculectomy into two separate coverage statements. Abdominoplasty coverage changed to cosmetic for all indications. Panniculectomy coverage has changed under both the Reconstruction column as well as the Cosmetic column. Removed pectus excavatum and pectus carinatum from this medical policy as it is now addressed on medical policy SUR701.044 Surgical Treatment of Pectus Excavatum and Pectus Carinatum. Reference 13 added; others removed. |
| 08/01/2021 | Document updated. The following changes were made to Coverage: 1) Changed position on injectable dermal fillers (e.g. Radiesse®, Sculptra®) from "cosmetic" to "may be considered reconstructive in cases of human immunodeficiency virus (HIV)-associated lipodystrophy in the presence of a functional impairment"; 2) Removed language on EGRIFTA™. Reference 6 removed. |
| 01/15/2021 | Document updated with literature review. The following change was made in Coverage: Fractional ablative laser fenestration for functional improvement of scars was removed from Table 1, as experimental, investigational and/or unproven. Added reference 15; others removed. |
| 04/15/2020 | Document updated with literature review. The following changes were made: Coverage section was revised and divided into two tables, one table focuses on clinical conditions and addresses Reconstructive and Cosmetic indications. Changes to the table addressing Reconstructive and Cosmetic indications include: 1) Editorial wording changes to Injectable Implant section; 2) the following was removed from Restoration of Body Form: As a general rule restoration should be performed within 2 years of the accident or initial injury. 3) Treatments addressing acne and Rosacea were moved to the second table. The second table notes conditions, treatments and/or surgeries and directs users to specific medical policies that address those topics. 4) Referral to SUR717.001 for Gender Assignment Surgery and Gender Reassignment Surgery with Related Services was added to the Mentoplasty, Genioplasty or chin implant section of the table. 5) Two references removed. Reference 17 added. |

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| 03/01/2019 | The following changes were made in Coverage: 1) Removed surgical reshaping of the nose for Rhinophyma from the cosmetic table and added refer to medical policy 801.030 For Nonpharmacologic Treatment of Rosacea. |
| 01/01/2018 | Document updated with literature review. The following change was made to Coverage: 1) Added "Fractional ablative laser fenestration for functional improvement of scars is considered experimental, investigational, and/or unproven for all indications." |
| 07/01/2017 | Document updated with literature review. The following was added to coverage: Cool sculpting (may also be known as cryolipolysis or fat freezing) is considered experimental, investigational, and/or unproven for all indications. The following was removed from the coverage section: Relume™ for treatment of Stretch Marks. |
| 08/15/2016 | Document updated with literature review. Coverage under Injectable Implant section, had Juliessa changed to JuliesseTM. Under the Reconstructive section and under the Cosmetic section ProlarynTM gel (formerly known as Radiesse or Juliessa Laryngeal Implant) was removed and replaced by Radiesse. |
| 01/01/2016 | The following was added to the Coverage section: Neurofibromas, cutaneous destruction is considered reconstructive when the following conditions exist that may interfere with normal function such as: symptomatic neurofibromas (painful, tender, infected); destruction of cutaneous neurofibromas that do not interfere with normal function are considered cosmetic. |
| 09/15/2015 | Medical document updated with literature review. The following was added to the coverage section: Mesotherapy-Injection for Lipolysis, is considered cosmetic for all indications and Submental fat in adult (i.e., double chin) treated with Kybella TM (deoxycholic acid) injections is considered cosmetic for all indications. |
| 08/15/2013 | Medical document updated with literature review. The following was added to the "Coverage" section under "Injectable Implant" – "Radiesse Laryngeal Implant for indications of vocal fold medialization and vocal fold insufficiency in accordance with FDA labeling" found under the "Reconstructive" column in the "Clinical Conditions/Reconstructive/Cosmetic" table. The following was removed "This policy is no longer scheduled for routine literature review and update." |
| 01/15/2012 | Medical document updated with literature review. The following was added: EGRIFTA is considered cosmetic for all indications, including, but not limited to the reduction of excess abdominal fat in the HIV-infected patients with lipodystrophy. |
| 03/15/2011 | Medical document updated. The coverage of Radiesse® was expanded by adding the following: Radiesse is considered cosmetic for all indications, including, but not limited to subdermal implantation for restoration and/or |

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| | correction of the signs of facial fat loss (lipodystrophy) in people with human immunodeficiency virus. |
| 04/15/2009 | Coverage revised to allow testicular prosthesis after orchiectomy for reconstruction after malignancy. |
| 03/15/2008 | Revised/updated entire document. This policy is no longer scheduled for routine literature review and update. |
| 02/15/2008 | Coverage revised |
| 09/15/2007 | Coverage revised |
| 03/15/2007 | Revised/updated entire document |
| 10/15/2006 | Revised/updated entire document |
| 03/01/2006 | Revised/updated entire document |
| 08/01/2005 | Revised/updated entire document |
| 11/01/1999 | Revised/updated entire document |
| 09/01/1999 | Revised/updated entire document |
| 05/01/1996 | Revised/updated entire document |
| 07/01/1994 | Revised/updated entire document |
| 01/01/1993 | Revised/updated entire document |
| 10/01/1992 | Revised/updated entire document |
| 05/01/1990 | New medical document |