

Clinical Policy: Cosmetic and Reconstructive Surgery

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Effective Date: 01/18

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[Revision Log](#)

Description

Medical necessity criteria for cosmetic or reconstructive surgery.

Not all cosmetic procedures are listed in this policy. The Medical Director has the final decision to deny coverage for services deemed cosmetic in nature and not medically necessary.

Policy/Criteria

- I. It is the policy of Pennsylvania Health and Wellness[®] (PHW) that *reconstructive surgery* is considered **medically necessary** when performed to improve the function of a body part after conservative therapy when the abnormality results from an illness, trauma or a congenital defect. Certain reconstructive procedures may be covered if improving appearance is the only benefit, e.g. post-mastectomy breast reconstruction.* These procedures may include, but are not limited to:
- A. Reconstruction due to trauma;
 - B. Skin tag removal when located in an area of friction with documentation of repeated irritation and bleeding (refer to Benefit Plan Contract);
 - C. Post-mastectomy or post significant lumpectomy resulting in asymmetry: breast reconstruction, including nipple reconstruction, tattooing and surgery on contralateral breast to restore symmetry;
 - D. Scar/keloid revisions/removal for members < 18 years old when accompanied by pain unresponsive to standard therapy and are recurrently infected, unstable, friable, or with functional impairment.
 - E. Procedures to correct a visible disfigurement which would affect the ability of a person to obtain or hold employment

Refer to the most current version of the Health Plan adopted nationally recognized decision support tools for other procedures that may be considered cosmetic in certain cases.

*Note: This includes reconstruction after prophylactic mastectomy with BRCA mutation if the mastectomy is a covered benefit in the State.

- II. It is the policy of PHW that *cosmetic surgery* is **not medically necessary** and generally not a covered benefit when performed to improve a patient's normal appearance and self-esteem. These procedures include, but are not limited to:
- A. Excision of excessive skin
 - B. Body contouring
 - C. Body lift
 - D. Breast augmentation
 - E. Liposuction, excluding lipoma as directed by InterQual[®] criteria
 - F. Surgery to correct unsatisfactory results from previous cosmetic and/or non-covered service

CLINICAL POLICY

Cosmetic and Reconstructive Surgery

- G. Revision, removal, or replacement of breast implants previously placed for cosmetic reasons
- H. Removal of excess skin or body contouring procedures following weight loss or bariatric surgery when removal is solely cosmetic
- I. Facial augmentation
- J. Abdominoplasty
- K. Dermabrasion
- L. Skin rejuvenation and resurfacing
- M. Electrolysis, laser hair removal
- N. Hair replacement
- O. Tattooing (except when covered for breast reconstruction post-mastectomy)
- P. Injectable filler
- Q. Circumcision revisions done only to improve appearance

Medical records must accompany all requests for plastic and reconstructive surgery, photographs are also commonly needed. Proof of conservative therapies attempted must be documented when applicable.

Background

Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, previous or concurrent surgeries, trauma, infection, tumors or disease. It is generally performed to improve the functioning of a body part and may or may not restore a normal appearance. Functional impairment is a health condition in which the normal function of a part of the body or organ system is less than age appropriate at full capacity, such as decreased range of motion, diminished eyesight or hearing, etc. that variably impacts activities of daily living.

Cosmetic surgery is performed to reshape normal structures of the body in order to improve the appearance and self-esteem of a patient. It is generally not considered medically necessary. This policy will provide general guidelines as to when cosmetic and reconstructive surgery is or is not medically necessary.

Reviews, Revisions, and Approvals	Date	Approval Date
References reviewed and updated	4/18	

References

1. American Society of Plastic Surgeons. Physician's guide to cosmetic surgery overview. <http://www.plasticsurgery.org/for-medical-professionals/resources-and-education/publications/physicians-guide-to-cosmetic-surgery.html>
2. DeLong MR, Tandon VJ, Rudkin GH, Da Lio AL. Latissimus Dorsi Flap Breast Reconstruction-A Nationwide Inpatient Sample Review. *Ann Plast Surg.* 2017 Mar 24.
3. Goldstein BG, Goldstein AO. Keloids and hypertrophic scars. In: UpToDate. Dellaville RP, Levy ML (Ed), UpToDate, Waltham, MA. Accessed 3/13/18.
4. Razdan SN, Cordeiro PG, Albornoz CR, et al. National Breast Reconstruction Utilization in the Setting of Postmastectomy Radiotherapy. *J Reconstr Microsurg.* 2017 Feb 24

CLINICAL POLICY

Cosmetic and Reconstructive Surgery



5. Ilonzo N, Tsang A, Tsantes S, et al. Breast reconstruction after mastectomy: A ten-year analysis of trends and immediate postoperative outcomes. *Breast*. 2017 Apr;32:7-12. doi: 10.1016/j.breast.2016.11.023. Epub 2016 Dec 16.