Clinical Policy: Cosmetic and Reconstructive Procedures

Reference Number: PA.CP.MP.31
Plan Effective Date: 01/2018 Coding Implications
Date of Last Revision: 09/2025 Revision Log

Description
Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, surgery, infection, tumors or disease.[1]

This policy outlines the medical necessity criteria for cosmetic and reconstructive procedures.

Note:
- *For criteria applicable to Medicare plans, please see MC.CP.MP.31 Cosmetic and Reconstructive Procedures.*
- *This policy should only be used if there are no available procedure specific criteria.*
- *Please refer to PA.CP.MP.95 Gender Affirming Procedures for treatment related to gender dysphoria*.

Policy/Criteria

I. It is the policy of PA Health and Wellness® (PHW) that *reconstructive procedures* are considered **medically necessary** when meeting one of the following:

A. Intent of the procedure meets one of the following:
   a. The procedure is performed to improve the function of an abnormal body part caused by illness, trauma, or a congenital defect after failure of conservative therapy (unless conservative therapy is not standard of care for the condition, or is contraindicated);
   b. Skin tag removal when located in an area that affects eyesight or in an area of friction with documentation of repeated irritation and bleeding;
   c. Scar/keloid revision/removal when accompanied by pain unresponsive to conservative therapy and is recurrently infected, unstable, friable; or with functional impairment;

B. Certain reconstructive procedures may be covered if improving appearance is the only benefit. These procedures may include, but are not limited to:
   1. Post-mastectomy, medically necessary lumpectomy, or other medically necessary breast surgery resulting in asymmetry: breast reconstruction, including nipple reconstruction, tattooing and surgery on contralateral breast to restore symmetry;
   2. Use of FDA-approved facial dermal injections [Poly-L-Lactic acid (Sculptra™), calcium hydroxylapatite microspheres (Radiesse®)] or autologous fat transfers for human immunodeficiency virus (HIV)-associated facial lipodystrophy syndrome (LDS).*

Note:
- Photographs may be requested, if applicable.
- *For Serostim (somatropin) for HIV associated wasting, see the following applicable pharmacy policy:

- PHW.PDL.014 Growth Hormone (Somapacitan, Somatrogon, Somatropin, Lonapegsomatropin-tcgd)
- CP.CPA.353 Human Growth Hormone (Somapacitan, Somatrogon, Somatropin, Lonapegsomatropin-tcgd)
- HIM.PA.161 Human Growth Hormone (Somapacitan, Somatrogon, Somatropin)
- PA.CP.PHAR.109 Tesamorelin (Egrifta SV)

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 clinical decision support criteria;
F. Surgery to correct unsatisfactory results from previous cosmetic and/or non-covered service;
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 transplantation, when not performed to correct permanent hair loss caused by disease or injury;
O. Tattooing (except when covered for breast reconstruction post-mastectomy);
P. Injectable filler;
Q. Circumcision revisions done only to improve appearance;
R. Mastopexy (except for breast reconstruction post-mastectomy, medically necessary lumpectomy, or other medically necessary breast surgery resulting in significant asymmetry);
S. Correction of inverted nipples;
T. Repair of diastasis recti;
U. Breast reconstruction for fibroadenomas or other benign lesions, unless medically necessary per clinical decision support criteria.

** It is the policy of PA Health & Wellness ® (PHW) that determinations for services that are considered not medically necessary must be considered on a case-by-case basis by a physician or ad hoc committee and must be made in accordance with the Benefit Plan Contract provisions and applicable state and federal requirements. Denials will require medical director review.

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.[2] 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.[3]

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 considered not medically necessary.[4]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT Codes That Support Coverage Criteria

CPT Codes Codes	Description
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm
11404	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm

CPT Codes Codes	Description
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm
11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11424	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm
11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
11440	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm
11443	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm
11444	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm
11446	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm
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)
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)
15788	Chemical peel, facial; epidermal

CPT Codes Codes	Description
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15220	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less
15221	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
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)
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions

CPT Codes Codes	Description
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy
19303	Mastectomy, simple, complete
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with implant
19328	Removal of intact breast implant
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19361	Breast reconstruction; with latissimus dorsi flap
19364	Breast reconstruction; with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap
19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)
19369	Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19380	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
19396	Preparation of moulage for custom breast implant
19499	Unlisted procedure, breast
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21137	Reduction forehead; contouring only

CPT Codes Codes	Description
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
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I
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 (eg,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 (eg, fibrous dysplasia), extracranial
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, 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 (eg, 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 (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm
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)
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) (eg, micro-ophthalmia)
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach

CPT Codes Codes	Description
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
21270	Malar augmentation, prosthetic material
21275	Secondary revision of orbitocraniofacial reconstruction
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach
21296	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach
61550	Craniectomy for craniosynostosis; single cranial suture
61552	Craniectomy for craniosynostosis; multiple cranial sutures
61556	Craniotomy for craniosynostosis; frontal or parietal bone flap
61557	Craniotomy for craniosynostosis; bifrontal bone flap
61558	Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); not requiring bone grafts
61559	Extensive craniectomy for multiple cranial suture craniosynostosis (eg, cloverleaf skull); recontouring with multiple osteotomies and bone autografts (e.g., barrel-stave procedure) (includes obtaining grafts)

HCPCS Codes	Description
G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) as a result of highly active antiretroviral therapy)
Q2026	Injection, Radiesse, 0.1 ml
Q2028	Injection, Sculptra, 0.5 mg

Reviews, Revisions, and Approvals	Revision Date	Approval Date
References reviewed and updated	4/18	05/18
Reorganized section 1 for clarity. Removed requirement that scar and keloid revisions must be in members under 18 years. Moved statement regarding documentation of medical records, photos. Removed specific mention of documentation of	10/19	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
conservative therapies in the medical records criteria. Reorganized description and background sections.		
Policy/Criteria 1.D add additional conditions regarding removal of breast implants.	1/20	1/4/2021
Removed "significant" in I.A.4.a. In II. N. changed "hair replacement" to "hair transplantation." Added additional not medically necessary indications i.e., (mastopexy except for breast reconstruction post-mastectomy or lumpectomy resulting in significant asymmetry, correction of inverted nipples, and repair of diastasis recti. Added criteria for dermal injections and autologous fat injections for HIV-associated FLS. Changed policy title and medical necessity statements to state "cosmetic procedures" or "reconstructive procedures" instead of "cosmetic surgery" or "reconstructive surgery." Added CPT and HCPCS codes for specified medically necessary indications. Added note to refer to CP.MP.95 Gender Affirming procedures for procedures related to treatment of gender dysphoria. Clarified in II.N. that hair transplant is not medically necessary, when not performed to correct permanent hair loss caused by disease or injury. Added the following applicable CPT codes: 15220,15221, 15775, 15776. Supporting references added. Added applicable CPT codes: 15771, 15772. CPT code description revised in 2021: 19318, 19325, 19328, 19340, 19342, 19357, 19361, 19364, 19367, 19368, 19369, 19370, 19371, and 19380. CPT 19324 and 19366 deleted in 2021. Clarified in I.A.1. failure of conservative therapy "(unless conservative therapy is not standard of care for the condition, or is contraindicated)." Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." Added the following codes from the retired Craniofacial Surgery policy; 21120, 21121, 21122, 21123, 21137, 21138, 21139, 21159, 21160, 21172, 21175, 21179, 21180, 21181, 21182, 21183, 21184, 21230, 21235, 21255, 21256, 21260, 21261, 21263, 21267, 21268, 21270, 21275, 21280, 21282, 21295, 21296, and craniectomy/craniotomy codes for craniosynostosis. Clarified in I.A.4.a. "Post-mastectomy,* medically necessary lumpectomy, or other medically necessary breast surgery." Updated II.R. "Mastopexy (except for breast reconstruction post-mastectomy, medically necessary lumpectomy, other medically necessary breast surgery resulting in significant asymmetry). In II.E., changed "InterQual" to "Decision Support Criteria." Added II.U. "Breast reconstruction for fibroadenomas or other benign	1/28/2022	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
lesions, unless medically necessary per clinical decision support criteria" to not medically necessary procedures. Added codes 19330 and 19499. Annual review. References reviewed, updated, and reformatted.		
Remove items: R. Mastopexy (except for breast reconstruction post-mastectomy, medically necessary lumpectomy, or other medically necessary breast surgery resulting in significant asymmetry) U. Breast reconstruction for fibroadenomas or other benign lesions, unless medically necessary per clinical decision support criteria.	02/21/2022	
Annual review completed. Added to I.A.4.b. "poly-L-lactic acid" and "calcium hydroxylapatite microspheres". Minor rewording with no clinical significance. References reviewed and updated. Reviewed by external specialist. ** It is the policy of PA Health & Wellness ® (PHW) that determinations for services that are considered **not medically necessary** must be considered on a case-by-case basis by a physician or ad hoc committee and must be made in accordance with the Benefit Plan Contract provisions and applicable state and federal requirements. Denials will require medical director review.	02/06/2023	
Annual review. Minor edits to I.A.4.b with no clinical significance. Updated pharmacy policies for Serostim (somatropin) in note. Removed CPT code 11310. References reviewed and updated. Reviewed by internal specialist.	10/2023	02/2024
Annual review. Added note to see MC.CP.MP.31 for Medicare health plans. Updated criteria numbering so that I.A.2.a. is now I.A.3. Added criteria to I.A.2. to include in an area that affects eyesight. Under I.A.3. replaced "standard" with "conservative. Moved notes about health plan-adopted nationally recognized decision support criteria and gender dysphoria to Description. Removed note regarding prophylactic mastectomy with BRCA mutation. Minor rewording in Background with no impact to criteria. References reviewed and updated. Reviewed by external specialist.	09/2024	01/2025
Annual review. Updated verbiage in Note under Description section for clarity. Reformatted Criteria I. for clarity. Previous criteria I.B. regarding photographs converted to a note. Coding and descriptions reviewed. References reviewed and updated.	09/2025	

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