Medical Policy: Cosmetic Surgery Procedures (Commercial)

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<tr>
<th>POLICY NUMBER</th>
<th>EFFECTIVE DATE</th>
<th>APPROVED BY</th>
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<tbody>
<tr>
<td>MG.MM.AD.07eC3</td>
<td>01/10/2020</td>
<td>MPC (Medical Policy Committee)</td>
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**IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:**

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies (LMRP). All coding and web site links are accurate at time of publication.

**Definitions**

<table>
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<td>Cosmetic surgery procedures are those intended solely to refine or reshape structures or surfaces that are not functionally impaired. They are performed to improve appearance or self-esteem, or for other psychological, psychiatric or emotional reasons.</td>
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<tr>
<td>Cosmetic surgery is differentiated from reconstructive surgery, which is generally designed to improve function, but will usually include an improvement in appearance of the body area involved.</td>
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<td>Cosmetic surgery procedures are usually not considered eligible for coverage. This includes, but is not limited to, treatments, drugs, products, hospital/facility charges, anesthesia, pathology/lab fees, radiology fees and professional fees by the surgeon, assistant surgeon, consultants and attending physicians.</td>
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If there is a discrepancy between this policy and a member’s plan of benefits, then the provision of the benefits will govern and rule.

Related Guidelines
Abdominoplasty/Panniculectomy (MCG #ACG: A-0497 [ACG] & #ACG: A-0498 [ACG])
Blepharoplasty
Breast Implants and Reconstruction
Chemical Peels
Dermabrasion
Gender Affirming/Reassignment Surgery
Gynecomastia Surgery (MCG #ACG: A-0273 [AC])
Phototherapy, Photochemotherapy and Photodynamic Therapy for Dermatologic Conditions
Pulsed Dye Laser Therapy for Cutaneous Vascular Lesions
Reduction Mammoplasty (MCG #ACG: A-0274 [ACG])
Surgical Correction of Chest Wall Deformities
Varicose Vein Treatment

Guideline
ConnectiCare regards the surgical procedures listed in the Applicable Coding Table as cosmetic (unless substantiating documentation is received that would otherwise indicate that the purpose of the procedure is to restore or improve bodily function or is otherwise medically necessary).

The following covered exceptions are deemed medically necessary:
1. Breast reconstruction for Poland Syndrome
2. Testicular implant (prosthesis) for the replacement of congenitally absent testes, or testes lost due to disease, injury or surgery

Limitations/Exclusions
1. The Plan does not cover cosmetic procedures under the following circumstances:
   • When performed solely for psychological reasons.
   • In the absence of documentation that substantiates the procedure is performed to restore or improve bodily function or is medically necessary.
     (For Poland Syndrome, see Surgical Correction of Chest Wall Deformities)
2. Ancillary services related to cosmetic procedures are not considered medically necessary and are therefore not covered.

Applicable Coding
To access the codes, please download the policy to your computer, and click on the paperclip icon within the policy

Applicable CPT and Diagnosis Codes
Revision history

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<tr>
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<tr>
<td>01/10/2020</td>
<td>Annual Review. Commercial policy. Medicare references removed.</td>
</tr>
<tr>
<td>12/12/2019</td>
<td>Reformatted and reorganized policy, transferred content to new template</td>
</tr>
<tr>
<td>12/09/2016</td>
<td>Added medical necessity language for testicular implants.</td>
</tr>
<tr>
<td>11/11/2016</td>
<td>Added that surgery for Poland Syndrome is regarded as a medically necessary reconstructive surgery.</td>
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