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## Reconstructive and Cosmetic Health Services

Policy Number: 2024M0084A  
Last Review Date: February 29, 2024

Effective Date: April 1, 2024  
Next Review Date: March 1, 2026

### Important Information - Please Read Before Using This Policy

UCare has developed medical policies to assist in the determination of coverage of a clinical service (such as a procedure, therapy, diagnostic test, medical device, etc.), when coverage requires determination of medical necessity. Clinical services referenced in UCare's medical policies may not be covered by every UCare plan. Coverage is determined by federal and state regulation and by member contract materials, such as the Evidence of Coverage (EOC), Member Contract, or Member Handbook. This medical policy alone does not guarantee coverage.

Coverage is subject to the benefits or restrictions of the member's specific plan, which will supersede this medical policy when applicable. Please refer to the end of this document to read "How Coverage Is Determined in Specific UCare Plans."

UCare's medical policies are periodically reviewed and updated using published clinical evidence. In addition to medical policies, UCare uses tools for determination of medical necessity that are developed by external sources, including but not limited to InterQual Criteria and Hayes Inc. Knowledge Center. This medical policy does not constitute the practice of medicine or medical advice. Treating health care providers are solely responsible for determining what care to provide to patients. Members should always consult their provider before making any decisions about medical care.

#### ADMINISTRATIVE PROCEDURE:

A prior authorization is required for reconstructive services listed here:

<https://www.ucare.org/providers/authorization>

For all other reconstructive procedures, prior authorization is not required. UCare may review medical records after the procedure to confirm that medical necessity criteria were met. The provider may choose to submit clinical information before the procedure by using the UCare prior authorization form.

UCare Prior Authorization and Medicare Pre-Determination Request Forms are available here ("Medical Authorization & Notification"):

<https://www.ucare.org/providers/authorization>

**DEFINITIONS AND SCOPE:**

**Reconstructive** services are intended primarily to restore function or to correct deformities that result from disease, injury, trauma or birth defects. The proposed reconstructive service must be of proven efficacy; and deemed likely to significantly improve or restore functional ability of the involved part of the body.

**Cosmetic** surgery may be surgical or nonsurgical, but is intended to improve appearance, rather than to correct a specific functional deficit.

**MEDICAL NECESSITY CRITERIA / CLINICAL CONSIDERATIONS:****RECONSTRUCTIVE SERVICES:**

Services are **RECONSTRUCTIVE** and **MEDICALLY NECESSARY** when **ALL** of the following are met:

1. Service is intended primarily to restore function and/or correct a physical abnormality resulting in a functional defect from:
  - Accidental injury,
  - Trauma,
  - Disease,
  - Previous surgery, or
  - Congenital malformations when likely to cause future physiologic impairment.
2. The functional defect results in either significant disability that interferes with activities of daily living or exacerbation of a medical condition.
3. Medical documents (submitted to UCare) substantiate how the proposed surgery will improve the function of the body part. Examples of documentation include (but are not limited to) operative reports, photographs, specialty consultations, or diagnostic imaging.
4. The primary purpose for the procedure is **NOT** cosmetic. The fact that physical appearance may change or improve as a result does not necessarily classify such surgery as cosmetic, as long as other criteria are met (i.e., functional defect, disability, exacerbation of medical condition).
5. The procedure is **NOT** done solely to relieve psychological symptoms or socially avoidant behavior.

Examples of **RECONSTRUCTIVE PROCEDURES** that are usually considered medically necessary include, but are not limited to:

1. Blepharoplasty (eye lid lift) – when visual field is impacted.
2. Breast implant – for Poland’s syndrome (congenital absence of breast).
3. Burn surgery – for treatment of severe burns.
4. Dermabrasion – using methods of controlled surgical scraping (dermaplaning) or carbon dioxide (CO<sub>2</sub>) laser for removal of superficial basal cell carcinomas and pre-cancerous actinic keratosis, when:
  - Conventional methods of removal such as cryotherapy, curettage, and excision, are impractical due to the number and distribution of the lesions; and
  - A trial of 5-fluorouracil (5-FU) (Efudex) or imiquimod (Aldara) has failed or is contraindicated.
5. Eye prosthesis – for absence or shrinkage of an eye due to birth defect, trauma, or surgical removal.
6. Facial surgery
  - To correct congenital, acquired, traumatic, or developmental anomalies that may be at risk of developing physiologic functional impairment (e.g., the craniofacial anomalies associated with Crouzon’s Syndrome and Treacher-Collins Syndrome).
  - External facial prosthesis when there is loss or absence of facial tissue due to disease, trauma, surgery, or a congenital defect, regardless of whether or not the facial prosthesis restores function.
  - Chin, cheek, or jaw reshaping (facial implants or soft tissue augmentation) for deformities of the maxilla or mandible resulting from trauma or disease.
7. Lipoma excision - when located in an area of repeated touch or pressure with documentation of tenderness and/or inhibition of the patient’s ability to perform activities of daily living.
8. Nasal surgery – when performed to repair and improve documented and significant respiratory function, repair deficits caused by trauma, correct congenital anatomic abnormalities, revise structural deformities produced by trauma or nasal cutaneous disease, or replace nasal tissue lost after tumor ablative surgery (e.g., nasal fracture, benign or malignant neoplasms, deviated nasal septum, congenital musculoskeletal deformities, nasal sinus infection or fistula).
9. Otoplasty (ear pinning) – for absent or deformed ears such as microtia (small, abnormally shaped or absent external ears) or anotia (total absence of the external ear and auditory canal) with functional deficiencies resulting from trauma, surgery, disease or congenital defect, when performed to improve hearing by directing sound into the ear canal.
10. Pectus excavatum repair – when documented functional impairment exists (e.g., decreased cardiac output and/or abnormal pulmonary function during exercise) or when future cardiovascular compromise is anticipated. (E.g., Nuss procedure could be used for this repair in mid-late childhood through young adult).
11. Port-wine stains; and other hemangiomas of the face or neck – using pulsed dye laser therapy and other pulsed light sources (IPLS; e.g., PhotoDerm VL). Any device utilized for this procedure must have FDA approval specific to the indication, otherwise it will be considered investigational.

12. Prosthetic material insertion or injection – for significant deformity from disease or trauma (E.g., treating facial lipodystrophy syndrome due to antiretroviral therapy in HIV-infected persons).
13. Scar revision/repair, including keloids, resulting from a covered procedure or an accidental injury when **AT LEAST ONE** of the following is met:
  - Includes significant symptoms of pain, burning, or itching, which cannot effectively be treated with non-opiate analgesics and/or steroid injections
  - Interferes with normal bodily function, such as the movement of a joint,
  - Is unstable and has a history of intermittent breakdown.
14. Skin tag removal – when located in an area of friction with documentation of repeated irritation and bleeding.
15. Tattooing – in conjunction with reconstructive breast surgery post-mastectomy and for marking for radiation therapy.
16. Testicular prosthesis – for replacement of congenitally absent testes, or testes lost due to disease, injury, or surgery.
17. 17. Vaginoplasty- For congenital syndromes, e.g. vaginal agenesis and intersex conditions (androgen insensitivity syndrome, congenital adrenal hyperplasia and gonadal agenesis) or acquired conditions, e.g. extensive surgery for pelvic tumors, pelvic trauma, and vaginal prolapse.

#### **COSMETIC SERVICES:**

Cosmetic services are **NOT MEDICALLY NECESSARY**.

Examples of **COSMETIC PROCEDURES** include, but are not limited to:

1. Abdominoplasty or panniculectomy performed primarily to improve appearance. Abdominoplasty involves the removal of excess skin and fat from the pubis to the umbilicus or above, and may include fascial plication of the rectus muscle diastasis and a neoumbilicoplasty. Panniculectomy involves the removal of hanging excess skin/fat in a transverse or vertical wedge but does not include muscle plication, neoumbilicoplasty or flap elevation. A cosmetic abdominoplasty is sometimes performed at the time of a functional panniculectomy.
2. Adipose tissue replacement by insertion or injection of prosthetic material
3. Breast augmentation (augmentation mammoplasty) of small but otherwise normal breasts.
4. Breast implant removal or revision for non-medical reasons.
5. Breast inverted nipple correction.
6. Breast lift (mastopexy) to treat sagging of the breast.
7. Diastasis recti repair
8. Ear piercing and earlobe repair to close a stretched pierce hole.
9. Excess skin excision – from thigh, leg, hip, buttock, arm, forearm or hand, submental fat pad (double chin), neck, or other areas.

10. Facial contouring – chin implant or cheek enhancement for external deformities not due to trauma or disease.
11. Facial rejuvenation procedures – e.g., rhytidectomy of face (face lift), eyelid lift, neck lift, brow lift, excision/correction of glabellar frown lines, injection of any filling material including but not limited to collagen (e.g., Zyderm), fat, or other autologous or foreign material grafts.
12. Flesh-color tattooing and cosmetics for the treatment of port-wine stains, hemangiomas, or birth marks.
13. Hair removal or replacement by any means.
14. Lipectomy removal of fatty tissue (e.g., suction-assisted liposuction, lipoplasty).
15. Medical treatments (including but not limited to services such as dermabrasion, chemical exfoliation, cryotherapy, liquid nitrogen, dry ice, CO2 snow, and laser resurfacing) for:
  - Photo-aged skin (e.g., wrinkling)
  - Dyschromias/pigmentations (e.g., melisma, lentigines)
  - Acne scarring
  - Telangectasias resulting from rosacea
16. “Moon Face” surgery to correct a side effect of cortisone therapy.
17. Otoplasty (ear pinning) – for lop ears, bat ears, or prominent or protruding ears without functional deficiencies (e.g., hearing loss) or traumatic injury.
18. Penis enlargement (phalloplasty).
19. Rhinoplasty – unless done to improve a functional impairment that cannot be addressed with septoplasty alone.
20. Sclerosing of spider veins and/or telangiectasis.
21. Septoplasty – performed solely to improve the patient’s appearance in the absence of any signs or symptoms of functional respiratory abnormalities.
22. Skin lesion removal – whenever done solely for cosmetic purposes.
23. Surgery performed to treat psychiatric or emotional distress, problems or disorders.
24. Tattoo removal – including excision and salabrasion treatment of decorative tattoos.
25. Treatment of NON port-wine stain hemangiomas and other vascular abnormalities that is performed primarily to alter or enhance cosmetic appearance; such as spider veins, spider angiomas, cherry angiomas, facial telangiectasias and strawberry hemangiomas.
26. Vaccination scar repair/revision.
27. Vaginal rejuvenation procedures – including, but not limited to, reduction of labia minor.
28. Vermilionectomy (lip shave), with mucosal advancement.

**REGULATORY STATUS:**

**1. U.S. FOOD AND DRUG ADMINISTRATION (FDA):**

Surgery is a procedure and, therefore, is not subject to FDA regulation.

**2. CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS):**

Medicare Part A covers inpatient costs, and Medicare Part B covers doctors' charges and outpatient costs, for reconstructive surgery in only three situations:

- To repair the body following an accidental injury,
- To improve the function -- not just the appearance -- of a body part that never developed formed properly,
- To reconstruct one or both breasts following a mastectomy.

The CMS National Coverage Determination (NCD) for Breast Reconstruction Following Mastectomy (140.2) states: Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered a relatively safe and effective noncosmetic procedure. Accordingly, program payment may be made for breast reconstruction surgery following removal of a breast for any medical reason.

Program payment may not be made for breast reconstruction for cosmetic reasons. (Cosmetic surgery is excluded from coverage under §1862(a)(10) of the Act.)

CMS may have a Local Coverage Determination (LCD) on individual reconstructive health services.

The National Coverage Determination (NCD) for Plastic Surgery to Correct "MOON FACE" (140.4) states: The cosmetic surgery exclusion precludes payment for any surgical procedure directed at improving appearance. The condition giving rise to the patient's preoperative appearance is generally not a consideration. The only exception to the exclusion is surgery for the prompt repair of an accidental injury or for the improvement of a malformed body member which coincidentally serves some cosmetic purpose. Since surgery to correct a condition of "moon face" which developed as a side effect of cortisone therapy does not meet the exception to the exclusion, it is not covered under Medicare (§1862(a)(10) of the Act).

**3. MINNESOTA DEPARTMENT OF HUMAN SERVICES (DHS):**

MN DHS in its provider manual states that reconstructive surgery, such as after a mastectomy or surgery for an injury, illness or other disease, or for a birth defect, is a covered health service. MN DHS does not cover cosmetic surgery. If staged plastic and reconstructive surgery is being proposed for correction of a congenital anomaly, the complete plan for future surgeries must be submitted with the first authorization.

**4. UNITED STATES DEPARTMENT OF LABOR:**

**The Women's Health and Cancer Rights Act of 1998:**

This legislation states a health plan providing health insurance coverage with medical and surgical benefits for a mastectomy shall ensure that in a case in which a mastectomy patient elects breast reconstruction, coverage is provided for all stages of reconstruction of the breast on which the mastectomy has been performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance, and the cost of prostheses and complications of mastectomy,

including lymphedemas, in the manner determined by the attending physician and the patient to be appropriate and consistent with any fee schedule contained in the plan. This provision is not limited to cancer of the breast (CMS).

**5. MANDATED BENEFITS UNDER MINNESOTA LAW:**

**Chapter 62A.304 Coverage For Port-Wine Stain Elimination.** Available at: <https://www.revisor.mn.gov/statutes/?id=62A.304>. Accessed February 29, 2024.

Current health insurance benefit mandates in Minnesota law, which apply to private, fully-insured group and nongroup policies, require benefits for port-wine stain elimination.

Subdivision 1. Scope of coverage. This section applies to all health plans as defined in section 62A.011 that provide coverage to a Minnesota resident.

Subdivision. 2. Required coverage. Every health plan included in subdivision 1 must cover elimination or maximum feasible treatment of port-wine stains for any covered person who is a Minnesota resident. No health carrier may reduce or eliminate coverage due to this requirement.

Subdivision. 3. Rate increases prohibited. The commissioner of commerce shall not approve any rate increases due to coverage required under subdivision 2. No health maintenance organization, as defined in chapter 62D, shall increase rates due to coverage required under subdivision 2.

**How Coverage Is Determined In Specific UCare Plans**

➤ **Commercial: UCare Individual and Family Plans, UCare Individual and Family Plans with M Health Fairview:**

Coverage is determined by the Member Contract. If there is a conflict between this medical policy and the individual Member Contract, the provisions of the Member Contract will govern.

➤ **Medicare Advantage: UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial, EssentiaCare**

Coverage is determined by guidance from the Centers for Medicare & Medicaid Services (CMS) and the applicable UCare Evidence of Coverage (EOC). This medical policy applies in the absence of CMS guidance and/or EOC language.

➤ **Medicaid – MinnesotaCare: Prepaid Medical Assistance Program (PMAP), UCare Connect (non-SNP/non-integrated), Minnesota Senior Care Plus (MSC+), and MinnesotaCare**

Coverage is determined by the applicable Evidence of Coverage (also known as the “Member Handbook”) and guidance from the DHS MHCP Provider Manual. This medical policy applies if DHS coverage criteria are not available.

➤ **Medicare Advantage – Dual Eligible Special Needs Plan: UCare Connect + Medicare and Minnesota Senior Health Options (MSHO)**

Medicare coverage is determined by the applicable Member Handbook (MSHO) or Evidence of Coverage (*UCare Connect + Medicare*) and guidance from the Centers for Medicare &

Medicaid Services (CMS). This medical policy applies in the absence of CMS guidance and/or EOC language.

Medicaid coverage is determined by the applicable Member Handbook (MSHO) or Evidence of Coverage (*UCare Connect + Medicare*), and guidance from the DHS MHCP Provider Manual. This medical policy applies if coverage criteria have not been determined by DHS.

<b>POLICY HISTORY:</b>	
<b>DATE</b>	<b>ACTION/DESCRIPTION</b>
08/17/2015	New Policy 2015M0084A reviewed by Medical Policy Committee.
08/27/2015	Reviewed and approved by the Quality Improvement Advisory and Credentialing Council (QIACC).
09/01/2015	Published to UCare.org.
4/27/2018	Revision of 2015 policy completed and approved by Medical Policy Committee
2/7/2022	Revision of 2018 Policy.
3/1/2022	Approval by Medical Policy Committee
2/29/2024	Revision of 2022 Policy
3/8/2024	Approval by Medical Policy Committee