

## Clinical Policy: Cosmetic and Reconstructive Surgery

Reference Number: CP.MP.31

Last Review Date: 03/19

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

This policy will provide general guidelines as to when cosmetic and reconstructive surgery is or is not medically necessary. 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 health plans affiliated with Centene Corporation® that *reconstructive surgery* is considered **medically necessary** when meeting all of the following:
  - A. Intent of the procedure meets one of the following:
    1. 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;
    2. Skin tag removal when located in an area of friction with documentation of repeated irritation and bleeding (refer to Benefit Plan Contract for any coverage restrictions);
    3. Scar/keloid revision/removal when accompanied by pain unresponsive to standard therapy and is recurrently infected, unstable, friable; or with functional impairment;
    4. 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. Post-mastectomy\* or significant lumpectomy resulting in asymmetry: breast reconstruction, including nipple reconstruction, tattooing and surgery on contralateral breast to restore symmetry;
  - B. Medical records with photographs are provided, as applicable.

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 Health Plans affiliated with Centene Corporation 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

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- 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

**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.

Reviews, Revisions, and Approvals	Date	Approval Date
Original creation	03/09	03/09
Template updated References reviewed Criteria for panniculectomy removed and placed into CP.MP.109	04/16	04/16
References reviewed and updated	4/17	04/17
References reviewed and updated	03/18	03/18
Minor reorganization to section I. without content change.	04/18	
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 conservative therapies in the medical records criteria. Reorganized description and background sections.	03/19	03/19

**References**

1. American Society of Plastic Surgeons. Cosmetic Procedures. American Society of Plastic Surgeons. <https://www.plasticsurgery.org/cosmetic-procedures>

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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 Hong AM. Keloids and hypertrophic scars. In: UpToDate. Dellaville RP, Levy ML (Ed), UpToDate, Waltham, MA. Accessed 3/7/19.
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
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.

#### **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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