BSC7.08	Reconstructive Services		
Original Policy Date:	January 11, 2008	**Effective Date:**	May 1, 2021
Section:	7.0 Surgery	**Page:**	Page 1 of 9

Policy Statement

The following is considered **not medically necessary**:

I. The procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery
II. The treating surgeon cannot or will not provide sufficient documentation, including (when appropriate) quality color photographs, which accurately depicts the extent of the clinical problem
III. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes
IV. The procedure is for cosmetic purposes only

The use of silicone type injectables (e.g., Sculptra) to treat HIV-related lipoatrophy when it is likely that the injection(s) will result in more than minimal improvement in appearance may be considered **medically necessary**.

NOTE: Refer to Appendix A to see the policy statement changes (if any) from the previous version.

Policy Guidelines

The California Reconstructive Surgery Act (Health & Safety Code Section 1367.63 and the Insurance Code Section 10123.88) defines "reconstructive surgery" as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do **either** of the following:

- Create a normal appearance to the extent possible
- Improve function

Only a licensed physician, podiatrist, or oral and maxillofacial surgeon who is competent to evaluate the specific clinical issues involved in the care requested may deny initial requests for authorization of coverage.

Cosmetic surgery is distinguished from reconstructive surgery. Cosmetic surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

For the purpose of this policy, the qualified reviewer will differentiate a normal structure from an abnormal one based on **any** of the following elements:

- The availability of published normative data for specific anatomic measurements (e.g., cephalometric data for orthognathic surgery)
- The normal structural changes that are accommodative responses to gain or loss of body mass. Note that procedures to address excess skin in the setting of prior significant weight loss due to treatment of obesity qualify as reconstructive surgery if, on medical review of the requests, they meet the criteria of the California Reconstructive Surgery Act. (See Medical Policy for Panniculectomy, Abdominoplasty, and Surgical Management of Diastasis Recti.)
- The normal structural changes that are associated with aging (e.g., breast ptosis)
- The normal structures wide range of accepted variations in diverse populations (e.g., nasal size and shape)
- The presence of a cosmetic implant, in the absence of adjacent native tissue structural pathology, does not constitute an abnormal structure (e.g., cosmetic unilateral, bilateral or asymmetrical saline breast implants)

In determining whether or not a procedure is likely to result in more than minimal improvement in appearance, the qualified reviewer will consider both the size and location of the structural abnormality.

Effective January 1, 2021, the following CPT code has been ***deleted***:

- **19324:** Mammaplasty, augmentation; without prosthetic implant

Effective January 1, 2021, the following CPT codes have been ***revised***:

- **19325:** Breast augmentation with implant
- **19357:** Tissue expander placement in breast reconstruction, including subsequent expansion(s)
- **19370:** Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy

Description

Reconstructive surgery, when it meets the definition under applicable state law, is a covered benefit. It is the intent of Blue Shield of California (BSC) to use definitions and make determinations consistent with the Reconstructive Surgery Act (AB 1621) which added Section 1367.63 to the California Health and Safety Code, Section 10123.88 to the Insurance Code and Section 14132.62 to the Welfare and Institutions Code.

Related Policies

- Blepharoplasty, Blepharoptosis Repair (Levator Resection) and Brow Lift (Repair of Brow Ptosis)
- Breast Implant Management
- Dermatologic Applications of Photodynamic Therapy
- Light Therapy for Psoriasis
- Nonpharmacologic Treatment of Rosacea
- Orthognathic Surgery
- Panniculectomy, Abdominoplasty and Surgical Management of Diastasis Recti
- Surgical Treatment of Gynecomastia
- Treatment of Varicose Veins/Venous Insufficiency

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

- N/A

Rationale

Blue Shield of California's intent is to use definitions and make determinations consistent with the Reconstructive Surgery Act (AB 1621) which added Section 1367.63 to the California Health and Safety Code, Section 10123.88 to the Insurance Code and Section 14132.62 to the Welfare and Institutions Code. AB 1621 (Figueroa and Leach) - As Amended: February 19, 1998. Summary: Requires health insurance and health care service plan contracts to cover reconstructive surgeries. Specifically, this bill[1]:

- Provides that health care service plans and disability insurers that cover hospital, medical or surgical benefits, including entities that provide Medi-Cal coverage, shall cover reconstructive surgeries
- Defines reconstructive surgery as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease if the surgery will either improve function or give a patient a normal appearance

References

1. Reconstructive Surgery Act (AB 1621). 1998. Accessed on April 13, 2021 from http://www.leginfo.ca.gov/pub/97-98/bill/asm/ab_1601-1650/ab_1621_bill_19980219_amended_asm.html.

Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Clinical indications for procedure/surgery
  - Documentation of any functional problems or limitations to be corrected by the procedure including the cause of the issue
  - Previous treatment(s) and response(s) (if applicable)
  - Proposed procedural treatment plan
- Office note(s) pertaining to the clinical problem and medical necessity of the procedure requested
- Quality color photographs which accurately depicts the extent of the clinical problem (as applicable)

Post Service (in addition to the above, please include the following):

- Procedure/Operative report(s)

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	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)
	11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
	11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
	11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
	11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
	15770	Graft; derma-fat-fascia
	15775	Punch graft for hair transplant; 1 to 15 punch grafts
	15776	Punch graft for hair transplant; more than 15 punch grafts
	15777	Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) (List separately in addition to code for primary procedure)
	15786	Abrasion; single lesion (e.g., keratosis, scar)
	15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
	15819	Cervicoplasty
	15824	Rhytidectomy; forehead
	15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
	15826	Rhytidectomy; glabellar frown lines
	15828	Rhytidectomy; cheek, chin, and neck
	15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
	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
	15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
	15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
	15876	Suction assisted lipectomy; head and neck
	15877	Suction assisted lipectomy; trunk
	15878	Suction assisted lipectomy; upper extremity
	15879	Suction assisted lipectomy; lower extremity

Type	Code	Description
	17380	Electrolysis epilation, each 30 minutes
	17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
	19316	Mastopexy
	19324	Mammaplasty, augmentation; without prosthetic implant ***(Deleted code effective 1/1/2021)***
	19325	Breast augmentation with implant ***(Code revision effective 1/1/2021)***
	19350	Nipple/areola reconstruction
	19355	Correction of inverted nipples
	19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s) ***(Code revision effective 1/1/2021)***
	19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy ***(Code revision effective 1/1/2021)***
	21086	Impression and custom preparation; auricular prosthesis
	21087	Impression and custom preparation; nasal prosthesis
	21088	Impression and custom preparation; facial prosthesis
	21089	Unlisted maxillofacial prosthetic procedure
	21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
	21121	Genioplasty; sliding osteotomy, single piece
	21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
	21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
	21125	Augmentation, mandibular body or angle; prosthetic material
	21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
	21137	Reduction forehead; contouring only
	21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
	21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
	21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)
	21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
	21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
	21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
	21209	Osteoplasty, facial bones; reduction
	21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
	21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
	21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
	21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
	21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
	21270	Malar augmentation, prosthetic material
	21280	Medial canthopexy (separate procedure)
	21282	Lateral canthopexy

Type	Code	Description
	21299	Unlisted craniofacial and maxillofacial procedure
	21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
	21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy
	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
	30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
	30420	Rhinoplasty, primary; including major septal repair
	30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
	30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
	30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
	31587	Laryngoplasty, cricoid split, without graft placement
	31599	Unlisted procedure, larynx
	31750	Tracheoplasty; cervical
	55970	Intersex surgery; male to female
	55980	Intersex surgery; female to male
	56805	Clitoroplasty for intersex state
	57291	Construction of artificial vagina; without graft
	57292	Construction of artificial vagina; with graft
	57335	Vaginoplasty for intersex state
	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
HCPCS	G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)
	J0591	Injection, deoxycholic acid, 1 mg ***(Code effective 7/1/2020)***
	Q2026	Injection, Radiesse, 0.1 ml
	Q2028	Injection, sculptra, 0.5 mg

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
01/11/2008	New Policy Adoption
04/25/2008	Policy Revision Revised Medical Policy. Policy title change from Cosmetic and Reconstructive Services
12/18/2009	Policy revision without position change Coding update
07/02/2010	Coding Update
09/13/2010	Coding Update
10/06/2010	Coding Update
01/04/2011	Coding Update
01/21/2011	Coding Update

Effective Date	Action
09/01/2011	Policy statement reformatted and coding update
03/29/2013	Coding Update
07/10/2013	Policy Revision
05/02/2014	Coding Update
04/30/2015	Policy revision with position change
12/04/2015	Policy revision without position change
07/01/2016	Policy revision without position change
07/01/2017	Policy revision without position change
07/01/2018	Policy statement clarification
08/01/2018	Policy revision without position change
03/01/2019	Coding update
07/01/2019	Policy revision without position change Coding update
05/01/2020	Annual review. Policy statement and guidelines updated. Coding update.
08/01/2020	Coding update
01/01/2021	Coding update
05/01/2021	Annual review. No change to policy statement.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well

as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT (No changes)	
BEFORE	**AFTER**
Reconstructive Services BSC7.08 **Policy Statement:** The following is considered **not medically necessary**: I. The procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery II. The treating surgeon cannot or will not provide sufficient documentation, including (when appropriate) quality color photographs, which accurately depicts the extent of the clinical problem III. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes IV. The procedure is for cosmetic purposes only The use of silicone type injectables (e.g., Sculptra) to treat HIV-related lipoatrophy when it is likely that the injection(s) will result in more than minimal improvement in appearance may be considered **medically necessary**.	**Reconstructive Services BSC7.08** **Policy Statement:** The following is considered **not medically necessary**: I. The procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery II. The treating surgeon cannot or will not provide sufficient documentation, including (when appropriate) quality color photographs, which accurately depicts the extent of the clinical problem III. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes IV. The procedure is for cosmetic purposes only The use of silicone type injectables (e.g., Sculptra) to treat HIV-related lipoatrophy when it is likely that the injection(s) will result in more than minimal improvement in appearance may be considered **medically necessary**.