

PHP_7.08 Cosmetic and Reconstructive Procedures			
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Section:	7.0 Surgery	Page:	Page 1 of 24

Policy Statement

This policy does not address criteria related to gender affirming surgeries/procedures. Refer to the Related Policies section below for policy reference.

Reconstructive Procedures

- I. Reconstructive procedures may be considered **medically necessary** when **any** of the following criteria are met (this list is not exhaustive; other procedures may also be considered and subject to medical review):
 - A. Acne procedures (CPT codes: 10040, 11900, 11901) such as intralesional injection or surgical drainage to treat painful acne lesions
 - B. Actinic keratoses treatments such as cryosurgery, curettage, and excision
 - C. Benign skin lesions treatments, including skin tag removal (CPT codes: 11200, 11201, 11300-11313, 17110-17111), for bleeding, pain, recent changes in physical appearance (e.g., color, size), obstruction of an orifice, clinically restricts eye function, or exposure to frequent irritation

Note: For any other indication, refer to Policy Statement II
 - D. For breast reconstructive procedures, may refer to policy: Gender Affirmation Surgery
 - E. Congenital chest wall deformity surgical correction (CPT codes: 21740, 21742, 21743) for **either** of the following:
 1. Pectus excavatum for **both** of the following:
 - a. Haller index is 3.25 or greater
 - b. **One** (1) of the following criteria documenting functional impairment are met:
 - i. Cardiac impairment including but not limited to conduction abnormalities, cardiac displacement, reduced cardiac output
 - ii. Pulmonary impairment as evidenced by paradoxical respirations or pulmonary function tests (PFTs) demonstrating restrictive or obstructive lung capacity
 - iii. Exercise intolerance as demonstrated by cardiopulmonary exercise testing (CPET) results that are below the predicted values (see [Policy Guidelines](#))
 2. Pectus carinatum or Poland syndrome with **one** (1) of the following criteria documenting functional impairment are met:
 - a. Cardiac impairment including but not limited to conduction abnormalities, cardiac displacement, reduced cardiac output
 - b. Pulmonary impairment as evidenced by paradoxical respirations or pulmonary function tests (PFTs) demonstrating restrictive or obstructive lung capacity
 - c. Exercise intolerance as demonstrated by cardiopulmonary exercise testing (CPET) results that are below the predicted values; (see [Policy Guidelines](#))
 - F. Ear or body piercing repair (CPT codes: 12001, 12011, 12051), for immediate post-injury treatment of traumatic laceration

Note: For any other indication, refer to Policy Statement II
 - G. Hemangioma treatment (CPT codes: 17106, 17107, 17108), including laser therapy, when a functional deficit (e.g., bleeding, ulceration, affecting a vital structure [e.g., nose, eyes, lips]) is documented
 - H. Hypertrophic scar revision (e.g., burn laceration, surgical incision, and keloid) (CPT codes: 11400-11446, 11900, 11901, 17110, 17111, 17999) when **both** of the following criteria are met

1. The treatment is expected to improve the significant functional deficit (e.g., contracture, limited range of motion)
 2. Treatment includes **one** (1) of the following:
 - a. intralesional injection of corticosteroid or 5-fluorouracil
 - b. surgical excision
 - c. cryotherapy
 - d. laser therapy
 - e. radiation therapy
 - I. 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
 - J. Vulvectomy (CPT codes: 56620, 56625) as part of surgery to treat cancer or pre-cancerous lesions (dysplasia)
- Note:** For vaginal rejuvenation procedures, refer to Policy Statement II

Cosmetic Procedures

- II. The following non-inclusive list of procedures is typically considered cosmetic and **not medically necessary** for **all** indications unless otherwise specified in Policy Statement I, or for the medically necessary treatment of gender dysphoria as described in Blue Shield of California Promise Medical Policy: Gender Affirmation Surgery. A medical exception may be considered when clinical records document a significant functional deficit that cannot be adequately addressed through conservative treatments.
 - A. Benign skin lesions (CPT codes: 11300-11313; 11400-11446; 17110-17111)
 - B. Body sculpting, non-surgical (e.g., cryolipolysis [also known as fat freezing; e.g., CoolSculpting], deoxycholic acid injection [e.g., Kybella, HCPCS code: J0591])
 - C. Breast augmentation with implants (CPT code: 19325)
 - D. Breast lift (mastopexy) (CPT code: 19316)
 - E. Comedone extraction, including when combined with light/laser technology (e.g., TheraClearX)
 - F. Dermabrasion (CPT codes: 15780-15783)
 - G. Grafting of autologous fat or tissue (CPT codes: 15769-15772)
 - H. Hairplasty (hair transplant) (CPT codes: 15775, 15776)
 - I. Hair removal, including for treatment of hirsutism or hypertrichosis (CPT codes: 17380, 17999)
 - J. Ear or body piercing (CPT code: 69090)
 - K. Ear lobe or body piercing repair (CPT codes: 12001, 12011, 12051)
 - L. Tattooing (CPT codes: 11920, 11921, 11922)
 - M. Tattoo removal (CPT codes: 11920, 11921, 11922, 15783)
 - N. Vaginal rejuvenation (e.g., labiaplasty, vulvectomy) (CPT codes: 56620, 56625) for indications other than cancerous or pre-cancerous lesions
 - O. Voice lifting procedures

Not Medically Necessary

- III. Health and Safety Code section 1367.63 requires the plan to cover reconstructive surgery necessary to correct or repair abnormal structures of the body caused by congenital defects, development abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance, to the extent possible. The procedure may be denied as **not medically necessary** in **any** of the following circumstances:
 - A. 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
 - B. The treating surgeon cannot or will not provide sufficient documentation, including (when appropriate) medical quality color photographs, which accurately depicts the extent of the clinical problem (see [Policy Guidelines](#) and [Documentation for Clinical Review](#) sections)

- C. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes
- D. The procedure is for [Cosmetic](#) purposes only

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

State Guideline Resources

Applicable State Guideline resources as of the effective date of this policy:

- I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline:
 - N/A
- II. Department of Health Care Services (DHCS) Provider Manual Guideline:
 - [TAR and Non-Standard Benefits List: Codes 10000 thru 19999 \(tar and non cd1\)](#)
 - [TAR and Non-Standard Benefits List: Codes 20000 thru 29999 \(tar and non cd2\)](#)
 - [TAR and Non-Standard Benefits List: Codes 50000 thru 59999 \(tar and non cd5\)](#)
 - [TAR and Non-Standard Benefits List: Codes 60000 thru 69999 \(tar and non cd6\)](#)
 - [TAR and Non-Standard Benefits List: Codes G0000 thru G9999 \(tar and non cdg\)](#)
 - [TAR and Non-Standard Benefits List: Codes H0000 thru J9999 \(tar and non cdh\)](#)
 - [TAR and Non-Standard Benefits List: Codes Q0000 thru Q9999 \(tar and non cdq\)](#)
- III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline:
 - N/A

Policy Guidelines

- **Cosmetic Surgery Definition**
 - Cosmetic surgery is distinguished from reconstructive surgery. "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.
- Only a licensed provider (e.g., 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.
- 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 Blue Shield of California Promise 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)

- **More than Minimal Improvement in Appearance**
 - 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.
- Requests for procedures or services will be considered in accordance with State and Federal Law.
- When procedures are intended to improve impaired function/functional deficit, coverage will be considered based on adequate documentation submitted for clinical review. Documentation must be provided upon request and prior to performing the procedure. This may include objective documentation of any impairment(s), study/test results, description and duration of conservative treatments, photographs, copies of consultations, and any other pertinent information.
- If a medical condition results from a cosmetic procedure, medically necessary services required to treat the medical condition will be eligible for coverage. Common, anticipated, side effects (e.g., nausea and vomiting that results in a prolonged hospital stay) are considered part of the cosmetic procedure and are ineligible for coverage.
- Normal cardiopulmonary exercise testing (CPET) results: peak oxygen content (PVO₂) >84% predicted; ventilatory anaerobic threshold (VAT) >40% PVO₂ (40–80%); maximum heart rate (HR_{max}) >90% age predicted; heart rate reserve (HRR) 80%; Ventilatory reserve (VR) MVV2VEmax >11 liters or VEmax/MVV x 100

Coding

See the [Codes table](#) for details.

Description

Reconstructive Surgery

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) Promise Health Plan 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.

Acne Vulgaris

Acne vulgaris is a chronic, inflammatory skin disease that primarily presents with open or closed comedones, papules, pustules, or nodules on the face or trunk and may result in pain, erythema, hyperpigmentation, or scars. Acne inversa (hidradenitis suppurativa) is a chronic follicular occlusive disease primarily affecting the axilla, waist, groin, perianal, perineal, and inframammary areas.

Actinic Keratosis

Actinic keratosis (AKs), also known as solar keratoses, are common, sun-induced skin lesions that are confined to the epidermis and have the potential to become a skin cancer. Various options exist for treating AKs, including cryosurgery with liquid nitrogen, topical drug therapy, and curettage. Less commonly performed treatments for AK include dermabrasion, excision, chemical peels, laser therapy, and photodynamic therapy.

Keloids and Hypertrophic Scars

Keloids and hypertrophic scars are fibroproliferative disorders that result from aberrant wound healing in predisposed individuals following trauma, inflammation, surgery, or burns. While hypertrophic scars do not exceed the margins of the original wound, keloids are characterized by continuous growth and invasion into the adjacent, healthy skin beyond the original wound boundary. Keloids are often associated with pain and itch, can be disfiguring, and impair function and quality of life. Keloids also have a marked tendency to recur when surgically excised. Although hypertrophic scars and, especially, keloids are widely perceived as difficult to treat and at high risk of recurrence, advances in the understanding of the pathophysiology of abnormal scars has led to improved therapeutic approaches and outcomes (Ogawa 2024). Numerous treatment options exist (e.g., intra-lesional corticosteroid injections, pressure therapy, surgical excision followed by immediate adjunctive postoperative low dose radiation therapy. Radiation is typically indicated for recurrent keloids or those at high risk of recurrence.

Pectus Defects

Pectus defects are a group of congenital conditions where the sternum is depressed back towards the spine (excavatum), protrudes forwards (carinatum) or more rarely is a mixture of both. For the majority of patients, it is well tolerated, but some patients are affected psychologically, physiologically, or both. A small number of patients have more extreme depression of their sternum that impedes their physiological reserve, which can occur when engaging in strenuous exercise (e.g., running) but can also limit moderate activity such as walking and climbing stairs. The effects can be so extreme that symptoms occur at rest or cause life-threatening compression of the major blood vessels and organs (Dunning 2024). When investigating a patient with pectus excavatum with suspected cardiac compression, cross-sectional imaging of the thorax to determine the Haller index. A Haller index of 3.25 is consistently used to determine the severe category.

Poland Syndrome

Poland syndrome is a rare congenital condition that is classically characterized by absence (aplasia) of chest wall muscles on one side of the body (unilateral) and abnormally short, webbed fingers (sybrachydactyly) of the hand on the same side (ipsilateral) (National Organization for Rare Disorders 2015). Affected individuals may have variable associated features, such as underdevelopment or absence of one nipple (including the darkened area around the nipple [areola]) and/or patchy absence of hair under the arm. In females, there may be underdevelopment or absence of one breast and subcutaneous tissues. In some cases, associated skeletal abnormalities may also be present, such as underdevelopment or absence of upper ribs; elevation of the shoulder blade (Sprengel deformity); and/or shortening of the arm, with underdevelopment of the forearm bones (i.e., ulna and radius). Surgical intervention, although rarely necessary, can be indicated for reasons including paradoxical movement of the chest wall, severe rib hypoplasia and aplasia, hypoplasia or aplasia of the female breast, and cosmetic indication for men and women with chest wall asymmetry (Tafti 2023).

Related Policies

- Gender Affirmation Surgery
- Panniculectomy, Abdominoplasty, and Surgical Management of Diastasis Recti
- Skeletal Remodeling
- Medical Services Committee Policy and Procedure: Utilization Management Decision Making & Timeframes

Benefit Application

Blue Shield of California Promise Health Plan is contracted with L.A. Care Health Plan for Los Angeles County and the Department of Health Care Services for San Diego County to provide Medi-Cal health benefits to its Medi-Cal recipients. In order to provide the best health care services and practices, Blue Shield of California Promise Health Plan has an extensive network of Medi-Cal primary care providers and specialists. Recognizing the rich diversity of its membership, our providers are given training and educational materials to assist in understanding the health needs of their patients as it could be affected by a member's cultural heritage.

The benefit designs associated with the Blue Shield of California Promise Medi-Cal plans are described in the Member Handbook (also called Evidence of Coverage).

California Children's Services (CCS) is a Medi-Cal benefit provided by the State in partnership with County Public Health Departments. Blue Shield Promise coordinates the benefits for eligible members. The CCS program provides medical case management, diagnostic and treatment services, and physical and occupational therapy services to children under the age 21 with CCS eligible medical conditions managed by CCS paneled providers. The program's goal is to provide medical and allied services necessary to achieve maximum physical and social function for children. Members identified with CCS-eligible conditions are referred to the County CCS program immediately upon identification.

Regulatory Status

State: 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:

- I. Create a normal appearance to the extent possible
- II. Improve function

An amendment to the Reconstructive Surgery Act states the following:

"As of July 1, 2010, "reconstructive surgery" shall include medically necessary dental or orthodontic services that are an integral part of reconstructive surgery...for cleft palate procedures. For the purposes of this section "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate."¹³

Health Equity Statement

Blue Shield of California Promise Health Plan's mission is to transform its health care delivery system into one that is worthy of families and friends. Blue Shield of California Promise Health Plan seeks to advance health equity in support of achieving Blue Shield of California Promise Health Plan's mission.

Blue Shield of California Promise Health Plan ensures all Covered Services are available and accessible to all members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

Rationale

Blue Shield of California Promise Health Plan's intent is to use definitions and make determinations consistent with the Reconstructive Surgery Act (Stats 1998, ch. 788 (AB 1621), as amended, 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. The law was subsequently amended by Stats 2009, ch. 604 (SB 630) and Stats 2011, Ch. 367 (AB 574). Summary: Required health insurance and health care service plan contracts to cover reconstructive surgeries. Specifically, this law:²⁹

- 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

Acne Treatment Procedures

Cryotherapy (cryoslush) treatment has insufficient published evidence to determine the safety and efficacy for the treatment of acne. A pilot clinical trial investigated the feasibility and efficacy of precision cryotherapy for acne vulgaris on a small sample of volunteers (n=20) using the TargetCool (RecensMedical Inc.) carbon dioxide-based device (Hong 2024). The authors reported a significant reduction (90.25%) in the acne lesion count by week 4, with clinical improvement indicated by the Investigator Global Assessment (IGA) scale score reduction (p<0.001). The erythema index (EI) showed notable improvements at weeks 1, 2, and 4. Study limitations (e.g., small size and short-term follow-up) are noted to impact the generalizability of the results.

Actinic Keratosis (AK)

There is significant evidence from prospective studies and comparative trials to support the use of cryosurgery as a readily available, rapid, and effective lesion-directed treatment for AKs. Clinically, cryosurgery has been reported to cure between 57% and 98.8% of AKs followed up over 3 months to 8.5 years (Eisen 2021).

Steeb et al (2020) conducted a systematic review and meta-analysis assessing the efficacy and safety of chemical peels for the treatment of actinic keratosis. A total of eight (8) trials were included in the systematic review (4 RCTs, 2 non-randomized controlled trials, and 2 single-arm studies). Data analysis and interpretation of results were challenged by the presence of multiple study designs and the investigation of multiple distinct comparisons. The studies included in the review were at a high risk for selection bias because only one study clearly described the generation of a random sequence and performed allocation concealment. None of the patients in the studies were blinded; blinding of the outcome assessor was described in one study. Additionally, the chosen efficacy outcomes refer to short-term clearance rates but may not reflect long-term results. Overall, the authors concluded that additional high-quality studies and a standardization of peeling protocols were warranted in order to appropriately determine the value of chemical peeling as a treatment for actinic keratoses.

Congenital Chest Wall Deformity Correction

Zens et al (2022) acknowledge that repair of pectus excavatum has cosmetic benefits, but the physiological impacts remain controversial. A single-center analysis was conducted to characterize the relationship between the degree of pectus excavatum and cardiopulmonary dysfunction seen on cardiac magnetic resonance (CMR; n=345) imaging, cardiopulmonary exercise testing (CPET; n=261), and pulmonary function testing (PFT; n=281). The right ventricular ejection fraction (RVEF) was <-2 in 32%, and the left ventricular ejection fraction (LVEF) Z-score was <-2 in 18%. CPET revealed 33% of patients had reduced aerobic fitness. PFT results were abnormal in 23.1% of patients. Adjusted analyses revealed the Haller index had significant (P<.05) inverse associations with RVEF and LVEF.

The authors concluded the severity of pectus excavatum is associated with ventricular systolic dysfunction. Pectus excavatum impacts right and left ventricular systolic function and can also impact exercise tolerance. The Haller index and correction index may be the most useful predictors of impairment.

Scar Revision, Including Burn and Keloid

Walsh et al (2023) conducted an evidence-based systematic review of recent advances in keloid treatments up to November 2020. The search was limited to prospective studies (n=108) that were peer-reviewed and reported on clinical outcomes of keloid therapies. The authors concluded that current literature supports silicone gel or sheeting with corticosteroid injections as first-line therapy for keloids. Adjuvant intralesional 5-fluorouracil (5-FU), bleomycin, or verapamil can be considered, although mixed results have been reported with each. Laser therapy can be used as independent therapy for keloids or in combination with intralesional corticosteroids or topical steroids with occlusion to improve drug penetration. Excision of keloids with immediate post-excision radiation therapy is an effective option for recalcitrant lesions. There is sparse but emerging evidence on the utilization of photodynamic therapy (PDT) in treating keloids and hypertrophic scars. Extracorporeal shockwave therapy (ESWT) as a monotherapy for keloids showed a reduction in volume, height, and appearance that was not significantly different compared to intralesional triamcinolone. Further long-term studies of the effect of ESWT would be interesting as an additional treatment modality prior to excision. Laser-assisted delivery of corticosteroids and combination of different lasers for treatment of keloids are emerging treatments.

Appendix 1

Professional Guidelines

Acne Vulgaris

The American Academy of Dermatology (AAD) issued guidelines for the care management of acne vulgaris with 18 evidenced-based recommendations and five (5) good practice statements (Reynolds 2024). The AAD made a good practice recommendation supporting the use of intralesional corticosteroid injections as an adjuvant therapy treatment option in patients with larger acne papules or nodules. The AAD found that the available evidence is insufficient to develop a recommendation on the use of acne lesion/comedo extraction, chemical peels (including glycolic acid, trichloroacetic acid, salicylic acid, Jessner's solution, or mandelic acid), or photodynamic therapy with aminolevulinic acid for the treatment of acne.

In 2023, the National Institute for Health and Care Excellence (NICE) published updated guidelines on the management of acne vulgaris and recommends the use of intralesional corticosteroids in treating severe inflammatory cysts.

Actinic Keratosis

The American Academy of Dermatology (AAD) issued guidelines for the care management of actinic keratosis with 18 recommendations based on the best available evidence (Eisen 2021). Strong recommendations are made for using ultraviolet protection, topical imiquimod, topical 5-fluorouracil, and cryosurgery. A conditional recommendation, based on moderate evidence, was made for treatment with cryosurgery over CO2 laser ablation and for treatment with aminolevulinic acid (ALA)- red light photodynamic therapy (PDT) over 35% trichloroacetic acid (TCA) peel.

Hirsutism

In 2018, the Endocrine Society issued clinical practice guidelines for the evaluation and treatment of Hirsutism (Martin et al., 2018). The goal in assessing hirsutism is to determine the specific etiology and to provide a baseline for the patient. There are two main approaches to the management of hirsutism that may be used either individually or in combination: pharmacologic therapies that target androgen production and action, and direct hair removal methods. The Endocrine Society suggests

pharmacotherapy as initial therapy. Cosmetic measures to manage hirsutism include methods that remove hair shafts from the skin surface (depilation) and those that extract hairs to above the bulb (epilation). Shaving is a popular depilation method that removes hair down to just below the surface of the skin. Chemical depilatory agents are also commonly used to dissolve the hair. Epilation methods (e.g., plucking or waxing) can cause some discomfort but are relatively safe and inexpensive. These methods do not cause an increase in hair diameter.

Hypertrophic Scar Revision, Including Burn and Keloid

In 2019, in the absence of guidelines on the use of superficial radiation therapy (SRT) for treatment of keloids a group of qualified dermatologists issued consensus guidelines with recommendations for treatment based on published evidence (Nestor 2019). The authors reported that an enormous body of literature has demonstrated the effectiveness of SRT as an adjunctive therapy for the treatment of keloid scars that are resistant to other therapies, postsurgical treatment of keloid excision suture lines with several fractions of SRT significantly reduces keloid recurrence rates, and with three (3) post-surgical fractions. Although effective outcomes can be achieved with single doses of SRT, long-term sequelae are improved with three doses.

In 2020, an international consensus recommendation for laser treatment of traumatic scars and contractures was published (Seago 2020). The panel members are unanimous in their view that lasers are a first-line therapy in the management of traumatic scars and contractures. The lasers that target all major chromophores in the skin have demonstrated utility in the management of traumatic scars including hemoglobin (e.g., 595-nm pulsed dye laser [PDL]), pigment (e.g., 532-, 694-, 755-, and 1064-nm lasers), and tissue water (e.g., 1,540- and 1,565-nm non-ablative fractional lasers [NAFL]), 2940- and 10,600-nm ablative fractional lasers (AFL), and full- field ablative lasers. The fractional lasers, especially AFL, have the most potential to treat the entire range of clinical issues as a single modality.

- For larger traumatic injuries such as burns, over 90% of panelists would begin laser treatment within 4 months or less, and 76% within 2 months or less. Early intervention to minimize pathological scar formation and related disability is an important paradigm shift in traumatic scar treatment, and an essential potential benefit of minimally invasive laser procedures.

Ogawa et al (2022) published an updated algorithms for the treatment and prevention of hypertrophic scars and keloids. Treatment of hypertrophic scars depends on scar contracture severity: if severe, surgery is the first choice. If not, conservative therapies are indicated. Conservative therapies (e.g., gel sheets, tape fixation, topical and injected external agents, should be administered on a case-by-case basis. Keloid treatment depends on whether they are small and single or large and multiple. Small and single keloids can be treated radically by surgery with adjuvant therapy (e.g., radiotherapy) or multimodal conservative therapy. For large and multiple keloids, volume- and number-reducing surgery is a choice. Regardless of the treatment(s), patients should be followed up over the long term.

Pectus Excavatum and Pectus Carinatum

In 2012, the American Pediatric Surgical Association (APSA) issued clinical practice guidelines with recommendation to assist pediatric surgeons and pediatricians in the evaluation and management of children with pectus carinatum.

- Without strong evidence for ideal timing of treatment, expert opinion suggests that the age for operative therapy must be individualized but is typically deferred until pubertal growth is nearly complete.
- For the compliant pectus deformity, nonoperative compressive orthotic bracing is usually an appropriate first line therapy as it does not preclude the operative option.

- Expert opinion suggests that the noncompliant chest wall deformity or significant asymmetry of the pectus carinatum deformity caused by a concomitant excavatum-type deformity may not respond to orthotic bracing.
- Open surgical reconstructive techniques are acceptable surgical options in the hands of experienced pediatric surgeons
- Unless there is some overwhelming indication for repair, operative repair of pectus chest wall deformities is to be discouraged in children ages 5 years and younger due to the risk of disruption of normal chest wall growth with resultant chest wall restriction.

In 2024, joint specialist societies issued best practice consensus guidelines on the treatment of patients with pectus abnormalities (Dunning et al 2024), including the following recommendations:

- Patients with severe pectus excavatum with a Haller index above 3.25 and objective evidence of cardiac compression benefit physiologically from surgical intervention. (Class I, Level of Evidence B)
- Some patients who experience shortness of breath and exercise intolerance but do not fit the preceding criteria may also benefit from surgery, but other objective parameters should be used to determine the likelihood of improvement in cardiovascular performance. (Class IIb, Level of Evidence C)
- For patients with very severe pectus excavatum and evidence of symptomatic malignant arrhythmias with no other cause identified, surgical treatment is indicated to mitigate the risk of death from that arrhythmia. (Class I, Level of Evidence C)
- Surgery is indicated in patients with syncope or presyncope due to severe pectus excavatum. (Class I, Level of evidence C)
- Patients with very severe pectus excavatum and dysphagia (not otherwise explained by esophageal pathology) should benefit from surgery to relieve these symptoms. (Class IIa, Level of Evidence C)
- Bracing is a highly effective and safe conservative treatment for patients with significant pectus carinatum and must be available to all suitable patients who wish to be treated for their condition. It has fewer risks and is cheaper than an operation and still provides good outcomes. (Class I, Level of Evidence B)

Poland Syndrome (PS)

In 2020, the Italian Association of Poland Syndrome (AISP) issued consensus-based recommendation for diagnosis and medical management of Poland syndrome (Baldelli 2020). AISP reports that there are no strict guidelines or indications regarding thoracic surgery in the current literature. The mandatory feature of PS is the agenesis or hypoplasia of the pectoralis major muscle (the sterno-costal head is always affected). In most cases, PS is unilateral. Presumed bilateral PS needs a more extensive differential diagnosis. Additional diagnostic criteria are hypo/aplasia of the homolateral mammary gland and nipples, and malformations of the homolateral upper limb (limited to or more severely affecting the central rays).

- The indication for thoracic surgery is usually related to severe rib cage anomalies, either regarding anterior chest wall (pectus excavatum, carinatum or combination of both) or ribs (rib agenesis).
- Respiratory symptoms are not common in PS patients. Lack of protection of lungs and other thoracic organs due to the rib cage defect (rib agenesis) does not indicate per se thoracoplasty during childhood.

References

Congenital Chest Wall Deformity (pectus carinatum, pectus excavatum, Poland syndrome)

1. Abid I, et al. Pectus Excavatum: A Review of Diagnosis and Current Treatment Options. J Am Osteopath Assoc 2017 Feb 1;117(2):106-113.

2. Albouaini K, et al. Cardiopulmonary exercise testing and its application. *Heart*. 2007 Oct;93(10):1285- 92.
3. American Pediatric Surgical Association [Internet]. Pectus carinatum guideline. 2012 Aug 8 [accessed 2025 Aug 8]. Available from: <https://apsapedisurg.org/resources/resources/practice-guidelines/apsa-guidelines/>
4. Baldelli I, et al. Consensus based recommendations for diagnosis and medical management of Poland syndrome (sequence). *Orphanet J Rare Dis*. 2020 Aug 5;15(1):201.
5. Dunning J, et al. The pectus care guidelines: best practice consensus guidelines from the joint specialist societies SCTS/MF/CWIG/BOA/BAPS for the treatment of patients with pectus abnormalities. *Eur J Cardiothorac Surg*. 2024 Jul 1;66(1):e2ae166.
6. Tafti D and Cecava ND. Poland syndrome [Internet]. In: UpToDate, Connor RF (Ed), Wolters Kluwer. 2023 May 22 [accessed 2025 Aug 8]. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK532259/>
7. Zens TJ, et al. The severity of pectus excavatum defect is associated with impaired cardiopulmonary function. *Ann Thorac Surg*. 2022 Sep;114(3):1015-1021.

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8. Deflorin C, et al. Physical management of scar tissue: A systematic review and meta-analysis. *J Altern Complement Med*. 2020 Oct;26(10):854-865.
9. Nestor MS, et al. Consensus guidelines on the use of superficial radiation therapy for treating nonmelanoma skin cancers and keloids. *J Clin Aesthet Dermatol*. 2019 Feb;12(2):12-18. Erratum in: *J Clin Aesthet Dermatol*. 2019 Jun;12(6):14.
10. Ogawa R. Keloids and hypertrophic scars [Internet]. In: UpToDate, Connor RF (Ed), Wolters Kluwer. 2024 May 1 [accessed 2025 Aug 8]. Available from: <https://www.uptodate.com/contents/keloids-and-hypertrophic-scars>
11. Waibel JS, et al. Randomized, controlled early intervention of dynamic mode fractional ablative CO2 laser on acute burn injuries for prevention of pathological scarring. *Lasers Surg Med*. 2020 Feb;52(2):117-124.
12. Willows BM, et al. Laser in the management of burn scars. *Burns*. 2017 Nov;43(7):1379-1389.

Other Indications

13. Steinberg B and Alquist E. Senate Bill SB 630. Accessed March 11, 2024 from http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0601-0650/sb_630_bill_20091011_chaptered.html
14. American College of Obstetricians and Gynecologists [Internet]. Committee Opinion 686: Breast and labial surgery in adolescents. 2017 Jan [Reaffirmed 2020; accessed 2025 Aug 8]. Available from: <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/01/breast-and-labial-surgery-in-adolescents>
15. American College of Obstetricians and Gynecologists [Internet]. Committee Opinion 795: Elective female genital cosmetic surgery. 2007 Sept [Reaffirmed 2023; accessed 2025 Aug 8]. Available from: <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/01/elective-female-genital-cosmetic-surgery>
16. American Society of Plastic Surgeons [Internet]. ASPS recommended insurance coverage criteria for third-party payers. Ear deformity: prominent ears. 2005 Dec [reaffirmed 2015 Jun; accessed 2025 Aug 8]. Available from: <https://www.plasticsurgery.org/for-medical-professionals/health-policy/recommended-insurance-coverage-criteria>
17. Calvisi L, et al. Microbotox: A prospective evaluation of dermatological improvement in patients with mild-to-moderate acne and erythematotelangiectatic rosacea. *J Cosmet Dermatol*. 2022;21(9):3747- 3753.
18. Eisen D, et al; American Academy of Dermatology. Focused update to the guidelines of care for the management of actinic keratosis: Executive summary. *J Am Acad of Dermatol*. 2022 Aug 01;87(2):373-374.e5.
19. Eisen D, et al. Guidelines of care for the management of actinic keratosis. *J Am Acad Dermatol*. 2021;85:e209-33.

20. Gallagher T, et al. Dermatologist use of intralesional triamcinolone in the treatment of acne. *J Clin Aesthet Dermatol*. 2020 Dec;13(12):41-43.
21. Hong JY, et al. Targeted precision cryotherapy for acne vulgaris. *Skin Res Technol*. 2024 Sep;30(9):e70045.
22. Martin KA, et al. Evaluation and treatment of hirsutism in premenopausal women: An Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2018 Apr 1;103(4):1233-1257.
23. National Institutes for Health and Care Excellence (NICE) [Internet]. Acne vulgaris: management. NICE guideline [NG198]. 2021 Jun 25 [last updated 2023 Dec 07; accessed 2025 Aug 8]. Available from: <https://www.nice.org.uk/guidance/ng198>
24. National Organization for Rare Disorders [Internet]. Poland syndrome. 1987 [updated 2015 Jun 30; accessed 2025 Aug 8]. Available from: <https://rarediseases.org/rare-diseases/poland-syndrome/>
25. Reynolds RV, et al. Guidelines of care for the management of acne vulgaris. *J Am Acad Dermatol*. 2024 May;90(5):1006.e1-1006.e30. Epub 2024 Jan 30. PMID: 38300170.
26. Steeb T, et al. Chemical peelings for the treatment of actinic keratosis: a systematic review and meta-analysis. *J Eur Acad Dermatol Venereol*. 2021 Mar;35(3):641-649.
27. Waldman A, et al. ASDS Guidelines Task Force: consensus recommendations regarding the safety of lasers, dermabrasion, chemical peels, energy devices, and skin surgery during and after isotretinoin use. *Dermatol Surg*. 2017 Oct;43(10):1249-1262.
28. Wilkie, G and Bartz, D. Vaginal rejuvenation: a review of female genital cosmetic surgery. *Obstet Gynecol Surg*. 2018 May;73(5): 287-292.
29. California Health & Safety Code § 1367.63; California Insurance Code § 10123.88 (Reconstructive Surgery Act), as amended. Accessed on August 28, 2026 from https://california.public.law/codes/health_and_safety_code_section_1367.63

State Guidelines

30. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes 10000 thru 19999. Accessed October 15, 2026, from https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/351D1F95-1B91-42CE-8CF4-A527B40E0120/tarandnoncd1.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO
31. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes 20000 thru 29999. Accessed October 15, 2026, from https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/28498959-F595-4CAE-8990-7AC8DF4583FC/tarandnoncd2.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO
32. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes 50000 thru 59999. Accessed October 15, 2026, from https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/A2178E0C-1094-4B94-9E27-77A8DB180824/tarandnoncd5.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO
33. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes 60000 thru 69999. Accessed October 15, 2026, from https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/188E317C-036C-4DDA-A24B-5707A57A73F4/tarandnoncd6.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO
34. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes G0000 thru G9999. Accessed October 15, 2026, from https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/95922E28-1647-44F7-8DCE-6F0AA1D93CFD/tarandnoncdg.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO
35. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes H0000 thru J9999. Accessed October 15, 2026, from https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/2C0FB6B1-AC15-4B48-A845-A2823573A3D8/tarandnoncdhj.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO
36. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes Q0000 thru Q9999. Accessed October 15, 2026, from

https://mcweb.apps.prds.cammiis.medi-cal.ca.gov/assets/116BE94D-20C0-47AC-AE75-60FC42DB888D/tarandnoncdg.pdf?access_token=6UyVkRRfByXTZEWlh8j8QaYyIPyP5ULO

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 depict the extent of the clinical problem (as applicable)

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

- Procedure/Operative report(s)

Coding

The list of codes in this Medical Policy is intended as a general reference and may not cover all codes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy.

Type	Code	Description
ReCPT®	10040	Extraction (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)
	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)
	11300	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less
	11301	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm
	11302	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm
	11303	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm
	11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
	11306	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
	11307	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
	11308	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm
	11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less

Type	Code	Description
	11311	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm
	11312	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm
	11313	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm
	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
	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

Type	Code	Description
	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
	11900	Injection, intralesional; up to and including 7 lesions
	11901	Injection, intralesional; more than 7 lesions
	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
	12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
	12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
	12051	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
	15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
	15770	Graft; derma-fat-fascia
	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
	15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
	15781	Dermabrasion; segmental, face
	15782	Dermabrasion; regional, other than face
	15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
	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)
	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

Type	Code	Description
	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
	17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm
	17107	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq cm
	17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq cm
	17110	Destruction (e.g., 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 (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions
	17380	Electrolysis epilation, each 30 minutes
	17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
	19316	Mastopexy
	19325	Breast augmentation with implant
	19350	Nipple/areola reconstruction
	19355	Correction of inverted nipples
	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
	21076	Impression and custom preparation; surgical obturator prosthesis
	21079	Impression and custom preparation; interim obturator prosthesis
	21080	Impression and custom preparation; definitive obturator prosthesis
	21086	Impression and custom preparation; auricular prosthesis
	21088	Impression and custom preparation; facial prosthesis
	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

Type	Code	Description
	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
	21299	Unlisted craniofacial and maxillofacial procedure
	21740	Reconstructive repair of pectus excavatum or carinatum; open
	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
	56620	Vulvectomy simple; partial
	56625	Vulvectomy simple; complete
	57291	Construction of artificial vagina; without graft
	57292	Construction of artificial vagina; with graft
	66683	Implantation of iris prosthesis, including suture fixation and repair or removal of iris, when performed
	69090	Ear piercing
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
	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
12/01/2025	New policy.
05/01/2026	Administrative update. State Guidelines section updated.
06/01/2026	Administrative update. Definitions of Decision Determinations section updated.
11/01/2026	Annual review. Policy statement, state guideline resources, and literature review updated. Definitions of Decision Determinations section updated. Policy title changed from Reconstructive Services to current one. Coding updated.

Definitions of Decision Determinations

Healthcare Services: For the purpose of this Medical Policy, Healthcare Services means procedures, treatments, supplies, devices, and equipment.

Medically Necessary or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

Criteria Determining Experimental/Investigational Status

Blue Shield of California Promise Health Plan may use the following criteria and definitions to make decisions about procedures, treatments, supplies, devices, and equipment.

The following reference may be used to help guide determinations for members over 21 years of age and/or non-California Children's Services (CCS) Program members:

- California Code of Regulations. Title 22 § 51056.1. Experimental Services. Accessed September 9, 2026 from [https://govt.westlaw.com/calregs/Document/I542BE1835B6111EC9451000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Document/I542BE1835B6111EC9451000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default))

The following reference may be used to help guide determinations for Medi-Cal members, as this framework has been approved by the Department of Health Care Services (DHCS) for use by California Children's Services (CCS):

- Department of Healthcare Services Numbered Letter 05-1020. Accessed September 9, 2026, from <https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-05-1020-Experimental-and-Investigational-Services.pdf>

The following policy language applies to the California Children's Services (CCS) Program and the Genetically Handicapped Persons Program (GHPP) found in the above link for DHCS Numbered Letter 05-1020:

Policy

- A. The California Children's Services (CCS) Program and the Genetically Handicapped Persons Program (GHPP) will not provide coverage for experimental services unless specifically authorized by law.
- B. The CCS Program and GHPP may provide coverage for an investigational service if:
 - 1. It is approved by the FDA under any Investigational New Drug (IND) Application; or
 - 2. It is authorized for use under the State of California's Right to Try Act; and
 - 3. Its use is consistent with its FDA-approved IND Application or the State of California's Right to Try Act;
- C. Additional criteria that will be considered in the adjudication process include:
 - 1. Conventional therapy will not adequately treat the intended patient's condition;
 - 2. Conventional therapy will not prevent progressive disability or premature death;
 - 3. The provider of the proposed service has a record of safety and success with it or equivalent to that of other providers of the investigational services;
 - 4. Other criteria (e.g., cost and availability) may be considered in the adjudication of a given request in cases in which more than one investigational service is available;
 - 5. There is reasonable expectation that the investigational service will significantly prolong the patient's life or will maintain or restore a range of physical and social function suited to activities of daily living; and
 - 6. The service is not being performed as part of a research study protocol. For a beneficiary with cancer who participates in a clinical trial for cancer, California Health and Safety Code (HSC) § 1370.6 requires that all routine patient care costs related to the clinical trial be covered if the beneficiary's CCS-paneled treating physician recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the enrollee. The coverage does not include investigational services that have not been approved by the FDA and that are associated with the clinical trial.

Feedback

Blue Shield of California Promise Health Plan is interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration. Our medical policies are available to view or download at www.blueshieldca.com/en/bsp/providers.

For medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Questions regarding the applicability of this policy should be directed to the Blue Shield of California Promise Health Plan Prior Authorization Department at (800) 468-9935, or the Complex Case Management Department at (855) 699-5557 (TTY 711) for San Diego County and (800) 605-2556 (TTY 711) for Los Angeles County or visit the provider portal at www.blueshieldca.com/en/bsp/providers.

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

Appendix A

Policy Statement	
BEFORE Red font: Verbiage to be removed	AFTER Blue font: Verbiage Changes/Additions
<p>Reconstructive Services PHP_7.08</p> <p>State Guidelines: Applicable Medi-Cal guidelines as of the publication of this policy (this guideline supersedes the criteria in the Policy Statement section below):</p> <ol style="list-style-type: none"> I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline: <ul style="list-style-type: none"> • N/A II. Department of Health Care Services (DHCS) Provider Manual Guideline: <ul style="list-style-type: none"> • <u>TAR and Non-Standard Benefits List: Codes 10000 thru 19999 (tar and non cd1)</u> • <u>TAR and Non-Standard Benefits List: Codes 20000 thru 29999 (tar and non cd2)</u> • <u>TAR and Non-Standard Benefits List: Codes 30000 thru 39999 (tar and non cd3)</u> • <u>TAR and Non-Standard Benefits List: Codes 50000 thru 59999 (tar and non cd5)</u> • <u>Local Educational Agency (LEA) Service: Speech Therapy (loc ed serv spe)</u> • <u>TAR and Non-Standard Benefits List: Codes G0000 thru G9999 (tar and non cdg)</u> • <u>TAR and Non-Standard Benefits List: Codes H0000 thru J9999 (tar and non cdhj)</u> • <u>TAR and Non-Standard Benefits List: Codes Q0000 thru Q9999 (tar and non cdq)</u> <p>The codes listed on the policy are included in the above Provider Manuals; however, there are no specific clinical guidelines.</p> 	<p>Cosmetic and Reconstructive Procedures PHP_7.08</p> <p>Policy Statement: This policy does not address criteria related to gender affirming surgeries/procedures. Refer to the Related Policies section below for policy reference.</p> <p>Reconstructive Procedures</p> <ol style="list-style-type: none"> I. Reconstructive procedures may be considered medically necessary when any of the following criteria are met (this list is not exhaustive; other procedures may also be considered and subject to medical review): <ol style="list-style-type: none"> A. Acne procedures (CPT codes: 10040, 11900, 11901) such as intralesional injection or surgical drainage to treat painful acne lesions B. Actinic keratoses treatments such as cryosurgery, curettage, and excision C. Benign skin lesions treatments, including skin tag removal (CPT codes: 11200, 11201, 11300-11313, 17110-17111), for bleeding, pain, recent changes in physical appearance (e.g., color, size), obstruction of an orifice, clinically restricts eye function, or exposure to frequent irritation Note: For any other indication, refer to Policy Statement II D. For breast reconstructive procedures, may refer to policy: Gender Affirmation Surgery E. Congenital chest wall deformity surgical correction (CPT codes: 21740, 21742, 21743) for either of the following: <ol style="list-style-type: none"> 1. Pectus excavatum for both of the following: <ol style="list-style-type: none"> a. Haller index is 3.25 or greater b. One (1) of the following criteria documenting functional impairment are met: <ol style="list-style-type: none"> i. Cardiac impairment including but not limited to conduction abnormalities, cardiac displacement, reduced cardiac output

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<p>Red font: Verbiage to be removed</p> <p>III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline:</p> <ul style="list-style-type: none"> N/A <p>Policy Statement: Any criteria that are not specifically addressed in the above Provider Manuals, please refer to the criteria below.</p> <p>I. In interpreting whether a proposed procedure meets the definition of reconstructive surgery, as defined by law, the procedure may be denied as not medically necessary under any of the following conditions:</p> <ol style="list-style-type: none"> The procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by providers specializing in reconstructive surgery The treating surgeon cannot or will not provide sufficient documentation, including (when appropriate) medical quality color photographs, which accurately depicts the extent of the clinical problem (see Policy Guidelines and Documentation for Clinical Review sections) There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes The procedure is for cosmetic purposes only <p>II. 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.</p>	<p>Blue font: Verbiage Changes/Additions</p> <ol style="list-style-type: none"> Pulmonary impairment as evidenced by paradoxical respirations or pulmonary function tests (PFTs) demonstrating restrictive or obstructive lung capacity Exercise intolerance as demonstrated by cardiopulmonary exercise testing (CPET) results that are below the predicted values (see Policy Guidelines) <p>2. Pectus carinatum or Poland syndrome with one (1) of the following criteria documenting functional impairment are met:</p> <ol style="list-style-type: none"> Cardiac impairment including but not limited to conduction abnormalities, cardiac displacement, reduced cardiac output Pulmonary impairment as evidenced by paradoxical respirations or pulmonary function tests (PFTs) demonstrating restrictive or obstructive lung capacity Exercise intolerance as demonstrated by cardiopulmonary exercise testing (CPET) results that are below the predicted values; (see Policy Guidelines) <p>F. Ear or body piercing repair (CPT codes: 12001, 12011, 12051), for immediate post-injury treatment of traumatic laceration Note: For any other indication, refer to Policy Statement II</p> <p>G. Hemangioma treatment (CPT codes: 17106, 17107, 17108), including laser therapy, when a functional deficit (e.g., bleeding, ulceration, affecting a vital structure [e.g., nose, eyes, lips]) is documented</p> <p>H. Hypertrophic scar revision (e.g., burn laceration, surgical incision, and keloid) (CPT codes: 11400-11446, 11900, 11901, 17110, 17111, 17999) when both of the following criteria are met</p> <ol style="list-style-type: none"> The treatment is expected to improve the significant functional deficit (e.g., contracture, limited range of motion) Treatment includes one (1) of the following:

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	<ul style="list-style-type: none"> a. intralesional injection of corticosteroid or 5-fluorouracil b. surgical excision c. cryotherapy d. laser therapy e. radiation therapy I. 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 J. Vulvectomy (CPT codes: 56620, 56625) as part of surgery to treat cancer or pre-cancerous lesions (dysplasia) Note: For vaginal rejuvenation procedures, refer to Policy Statement II <p>Cosmetic Procedures</p> <ul style="list-style-type: none"> II. The following non-inclusive list of procedures is typically considered cosmetic and not medically necessary for all indications unless otherwise specified in Policy Statement I, or for the medically necessary treatment of gender dysphoria as described in Blue Shield of California Promise Medical Policy: Gender Affirmation Surgery. A medical exception may be considered when clinical records document a significant functional deficit that cannot be adequately addressed through conservative treatments. <ul style="list-style-type: none"> A. Benign skin lesions (CPT codes: 11300-11313; 11400-11446; 17110-17111) B. Body sculpting, non-surgical (e.g., cryolipolysis [also known as fat freezing; e.g., CoolSculpting], deoxycholic acid injection [e.g., Kybella, HCPSC code: J0591]) C. Breast augmentation with implants (CPT code: 19325) D. Breast lift (mastopexy) (CPT code: 19316) E. Comedone extraction, including when combined with light/laser technology (e.g., TheraClearX) F. Dermabrasion (CPT codes: 15780-15783) G. Grafting of autologous fat or tissue (CPT codes: 15769-15772) H. Hairplasty (hair transplant) (CPT codes: 15775, 15776)

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	<p>I. Hair removal, including for treatment of hirsutism or hypertrichosis (CPT codes: 17380, 17999)</p> <p>J. Ear or body piercing (CPT code: 69090)</p> <p>K. Ear lobe or body piercing repair (CPT codes: 12001, 12011, 12051)</p> <p>L. Tattooing (CPT codes: 11920, 11921, 11922)</p> <p>M. Tattoo removal (CPT codes: 11920, 11921, 11922, 15783)</p> <p>N. Vaginal rejuvenation (e.g., labiaplasty, vulvectomy) (CPT codes: 56620, 56625) for indications other than cancerous or pre-cancerous lesions</p> <p>O. Voice lifting procedures</p> <p>Not Medically Necessary</p> <p>III. Health and Safety Code section 1367.63 requires the plan to cover reconstructive surgery necessary to correct or repair abnormal structures of the body caused by congenital defects, development abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance, to the extent possible. The procedure may be denied as not medically necessary in any of the following circumstances:</p> <p>A. 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</p> <p>B. The treating surgeon cannot or will not provide sufficient documentation, including (when appropriate) medical quality color photographs, which accurately depicts the extent of the clinical problem (see Policy Guidelines and Documentation for Clinical Review sections)</p> <p>C. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes</p> <p>D. The procedure is for Cosmetic purposes only</p> <p>State Guideline Resources: Applicable State Guideline resources as of the effective date of this policy:</p>

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