BSC7.08	Cosmetic and Reconstructive Procedures		
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Section:	7.0 Surgery	**Page:**	Page 1 of 22

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 **ALL** of the following criteria are met:
   A. Procedure is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease
   B. The purpose of the procedure is **EITHER** of the following:
      1. To improve function
      2. To create a normal appearance (to the extent possible) **AND** more than minimal improvement in appearance of the individual in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery.
   C. **Any** of the following items may be considered medically necessary when criteria are met (this list is not exhaustive; other procedures may also be considered):
      1. Acne procedures (10040, 11900, 11901) such as intralesional injection or surgical drainage to treat painful acne lesions.
      2. Actinic keratoses treatments such as cryosurgery, curettage, and excision.
      3. Benign skin lesions treatments, including skin tag removal (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.
      4. For breast reconstructive procedures, refer to
         - Gender Affirmation Surgery
         - Reconstructive Breast Surgery/Management of Breast Implants
         - Reduction Mammaplasty for Breast-Related Symptoms
         - Surgical Treatment of Gynecomastia
      5. Congenital chest wall deformity surgical correction (21740, 21742, 21743) for EITHER of the following:
         a. Pectus excavatum for BOTH of the following:
            i. Haller index is 3.25 or greater;
            ii. **ONE** (1) of the following criteria documenting functional impairment are met:
               - 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; or
               - Exercise intolerance as demonstrated by cardiopulmonary exercise testing (CPET) results that are below the predicted values; (See Policy Guidelines).

b. Pectus carinatum or Poland syndrome with **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; or
   iii. Exercise intolerance as demonstrated by cardiopulmonary exercise testing (CPET) results that are below the predicted values; (See Policy Guidelines)

6. Ear or body piercing repair (12001, 12011, 12051), for immediate post-injury treatment of traumatic laceration
   Note: For any other indication, refer to Policy Statement II.
7. Hemangioma treatment (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.
8. Hypertrophic scar revision (e.g., burn laceration, surgical incision, and keloid) (11400 - 11446, 11900, 11901, 17110, 17111, 17999) when **BOTH** of the following criteria are met
   a. The treatment is expected to improve the significant functional deficit (e.g., contracture, limited range of motion) and
   b. Treatment includes ONE (1) of the following:
      i. intralesional injection of corticosteroid or 5-fluorouracil;
      ii. surgical excision.
9. Vulvectomy (56620, 56625)
   a. Vulvectomy as part of surgery to treat cancer or pre-cancerous lesions (dysplasia) is considered medically appropriate.
   Note: For vaginal rejuvenation procedures, refer to Policy Statement II.
10. Other procedures may be subject to medical review.

D. If there is no other more appropriate surgical procedure that will be rendered for the individual

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 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 (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, CPT J0591]);
   C. Breast augmentation with implants (19325);
   D. Breast lift (mastopexy) (19316);
   E. Comedone extraction, including when combined with light/laser technology (e.g., TheraClearX);
   F. Dermabrasion (15780 - 15783);
   G. Grafting of autologous fat or tissue (15769 - 15772);
   H. Hairplasty (hair transplant) (15775, 15776);
   I. Hair removal, including for treatment of hirsutism or hypertrichosis (17380, 17999);
   J. Ear or body piercing (69090);
   K. Ear lobe or body piercing repair (12001, 12011, 12051);
   L. Tattooing (CPT 11920, 11921, 11922);
   M. Tattoo removal (CPT 11920, 11921, 11922, 15783);

N. Vaginal rejuvenation (e.g., labiaplasty, vulvectomy) (56620, 56625) for indications other than cancerous or pre-cancerous lesions;
O. Voice lifting procedures.

III. 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

- 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 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 (HRmax) >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) 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 (symbrachydactyly) 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

- Blepharoplasty, Blepharoptosis Repair (Levator Resection) and Brow Lift (Repair of Brow Ptosis)
- Cleft Palate - Dental Related Services
- Fractional Carbon Dioxide (CO2) Laser Ablation Treatment of Hypertrophic Scars or Keloids for Functional Improvement
- Gender Affirmation Surgery
- Nasal Septoplasty
- Orthognathic Surgery
- Panniculectomy, Abdominoplasty, and Surgical Management of Diastasis Recti
- Reconstructive Breast Surgery/Management of Breast Implants
- Reduction Mammaplasty for Breast-Related Symptoms
- Surgical Treatment of Gynecomastia

Benefit Application

Benefit determinations should be based in all cases on the applicable member health services contract language. To the extent there are conflicts between this Medical Policy and the member health services 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 law may prohibit health plans from denying FDA-approved Healthcare Services as investigational or experimental. In these instances, Blue Shield of California may be obligated to determine if these FDA-approved Healthcare Services are Medically Necessary.

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

Rationale

Blue Shield of California'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[28]:

- 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 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 in 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.

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Hypertrophic Scar Revision, Including Burn and Keloid

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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

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
CPT®	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
	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

Type	Code	Description
	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
	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)
	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
	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

Type	Code	Description
	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)
	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)
	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
	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

Type	Code	Description
	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
	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
	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

Type	Code	Description
	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
	56620	Vulvectomy simple; partial
	56625	Vulvectomy simple; complete
	56805	Clitoroplasty for intersex state
	57291	Construction of artificial vagina; without graft
	57292	Construction of artificial vagina; with graft
	57335	Vaginoplasty for intersex state
	66683	Implantation of iris prosthesis, including suture fixation and repair or removal of iris, when performed ***(Code effective 1/1/2025)***
	69090	Ear piercing
	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
	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
09/01/2011	Policy statement reformatted and coding update

Effective Date	Action
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.
06/01/2022	Annual review. Policy statement and guidelines updated.
10/01/2022	Administrative update.
06/01/2023	Annual review. Policy statement and guidelines updated.
06/01/2024	Annual review. No change to policy statement.
02/01/2025	Coding update
04/01/2025	Administrative update.
06/01/2025	Annual review. No change to policy statement.
08/01/2026	Annual review. No change to policy statement.
09/01/2026	Annual review. Policy statement, guidelines and literature updated. Policy title changed from Reconstructive Services to current one. Coding Update

Feedback

Blue Shield of California 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 or 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/provider.

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

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: 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 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 reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT	
BEFORE Red font: Verbiage removed	**AFTER** Blue font: Verbiage Changes/Additions
Reconstructive Services BSC7.08 **Policy Statement:**	**Cosmetic and Reconstructive Procedures BSC7.08** **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 **ALL** of the following criteria are met: A. Procedure is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease B. The purpose of the procedure is **EITHER** of the following: 1. To improve function 2. To create a normal appearance (to the extent possible) **AND** more than minimal improvement in appearance of the individual in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery. C. **Any** of the following items may be considered medically necessary when criteria are met (this list is not exhaustive; other procedures may also be considered): 1. Acne procedures (10040, 11900, 11901) such as intralesional injection or surgical drainage to treat painful acne lesions. 2. Actinic keratoses treatments such as cryosurgery, curettage, and excision. 3. Benign skin lesions treatments, including skin tag removal (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.

POLICY STATEMENT	
BEFORE Red font: Verbiage removed	**AFTER** Blue font: **Verbiage Changes/Additions**
	Note: For any other indication, refer to Policy Statement II. 4. For breast reconstructive procedures, refer to • Gender Affirmation Surgery • Reconstructive Breast Surgery/Management of Breast Implants • Reduction Mammaplasty for Breast-Related Symptoms • Surgical Treatment of Gynecomastia 5. Congenital chest wall deformity surgical correction (21740, 21742, 21743) for EITHER of the following: a. Pectus excavatum for BOTH of the following: i. Haller index is 3.25 or greater; ii. **ONE** (1) of the following criteria documenting functional impairment are met: • 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; or • Exercise intolerance as demonstrated by cardiopulmonary exercise testing (CPET) results that are below the predicted values; (See Policy Guidelines). b. Pectus carinatum or Poland syndrome with **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)

POLICY STATEMENT	
BEFORE Red font: Verbiage removed	**AFTER** Blue font: **Verbiage Changes/Additions**
	demonstrating restrictive or obstructive lung capacity; or iii. Exercise intolerance as demonstrated by cardiopulmonary exercise testing (CPET) results that are below the predicted values; (See Policy Guidelines) 6. Ear or body piercing repair (12001, 12011, 12051), for immediate post-injury treatment of traumatic laceration **Note**: For any other indication, refer to Policy Statement II. 7. Hemangioma treatment (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. 8. Hypertrophic scar revision (e.g., burn laceration, surgical incision, and keloid) (11400 - 11446, 11900, 11901, 17110, 17111, 17999) when **BOTH** of the following criteria are met a. The treatment is expected to improve the significant functional deficit (e.g., contracture, limited range of motion) and b. Treatment includes ONE (1) of the following: i. intralesional injection of corticosteroid or 5-fluorouracil; ii. surgical excision. 9. Vulvectomy (56620, 56625) a. Vulvectomy as part of surgery to treat cancer or pre-cancerous lesions (dysplasia) is considered medically appropriate. **Note**: For vaginal rejuvenation procedures, refer to Policy Statement II. 10. Other procedures may be subject to medical review. D. If there is no other more appropriate surgical procedure that will be rendered for the individual

POLICY STATEMENT	
BEFORE **Red font: Verbiage removed**	**AFTER** **Blue font: Verbiage Changes/Additions**
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: A. 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 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 alternative approved medical or surgical intervention with equal or superior clinical outcomes D. The procedure is for cosmetic purposes only	**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 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 (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, CPT J0591]); C. Breast augmentation with implants (19325); D. Breast lift (mastopexy) (19316); E. Comedone extraction, including when combined with light/laser technology (e.g., TheraClearX); F. Dermabrasion (15780 - 15783); G. Grafting of autologous fat or tissue (15769 - 15772); H. Hairplasty (hair transplant) (15775, 15776); I. Hair removal, including for treatment of hirsutism or hypertrichosis (17380, 17999); J. Ear or body piercing (69090); K. Ear lobe or body piercing repair (12001, 12011, 12051); L. Tattooing (CPT 11920, 11921, 11922); M. Tattoo removal (CPT 11920, 11921, 11922, 15783); N. Vaginal rejuvenation (e.g., labiaplasty, vulvectomy) (56620, 56625) for indications other than cancerous or pre-cancerous lesions; O. Voice lifting procedures.

POLICY STATEMENT	
BEFORE **Red font: Verbiage removed**	**AFTER** **Blue font: Verbiage Changes/Additions**
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**.	III. 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**.