| BSC7.08 | Reconstructive Services | | |
|---|---|---|---|
| **Original Policy Date:** | January 11, 2008 | **Effective Date:** | April 1, 2025 |
| **Section:** | 7.0 Surgery | **Page:** | Page 1 of 9 |

## Policy Statement

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

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**.

**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)

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.

**Coding**
See the Codes table for details.

## Description

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

## Related Policies

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

## Benefit Application

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

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

## Regulatory Status

**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 (AB 1621) which added Section 1367.63 to the California Health and Safety Code, Section 10123.88 to the Insurance Code and Section 14132.62 to the Welfare and Institutions Code. AB 1621 (Figueroa and Leach) - As Amended: February 19, 1998. Summary: Requires health insurance and health care service plan contracts to cover reconstructive surgeries. Specifically, this bill[1]:

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

## References

1. Reconstructive Surgery Act (AB 1621). 1998. Accessed on May 13, 2024 from http://www.leginfo.ca.gov/pub/97-98/bill/asm/ab_1601-1650/ab_1621_bill_19980219_amended_asm.html

## Documentation for Clinical Review

**Please provide the following documentation:**

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

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

- Procedure/Operative report(s)

## Coding

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

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

| Type | Code | Description |
|---|---|---|
| CPT® | 11920 | Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less |
| | 11921 | Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm |
| | 11922 | Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure) |
| | 11950 | Subcutaneous injection of filling material (e.g., collagen); 1 cc or less |
| | 11951 | Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc |
| | 11952 | Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc |
| | 11954 | Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc |
| | 15770 | Graft; derma-fat-fascia |
| | 15775 | Punch graft for hair transplant; 1 to 15 punch grafts |
| | 15776 | Punch graft for hair transplant; more than 15 punch grafts |
| | 15777 | Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) (List separately in addition to code for primary procedure) |
| | 15786 | Abrasion; single lesion (e.g., keratosis, scar) |
| | 15787 | Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure) |
| | 15819 | Cervicoplasty |
| | 15824 | Rhytidectomy; forehead |
| | 15825 | Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap) |
| | 15826 | Rhytidectomy; glabellar frown lines |
| | 15828 | Rhytidectomy; cheek, chin, and neck |
| | 15829 | Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap |
| | 15832 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh |
| | 15833 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg |
| | 15834 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip |
| | 15835 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock |
| | 15836 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm |
| | 15837 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand |
| | 15838 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad |
| | 15839 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area |
| | 15876 | Suction assisted lipectomy; head and neck |
| | 15877 | Suction assisted lipectomy; trunk |
| | 15878 | Suction assisted lipectomy; upper extremity |
| | 15879 | Suction assisted lipectomy; lower extremity |
| | 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 |
| | 21742 | Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy |
| | 21743 | Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy |
| | 30400 | Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip |

| Type | Code | Description |
|---|---|---|
| | 30410 | Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip |
| | 30420 | Rhinoplasty, primary; including major septal repair |
| | 30430 | Rhinoplasty, secondary; minor revision (small amount of nasal tip work) |
| | 30435 | Rhinoplasty, secondary; intermediate revision (bony work with osteotomies) |
| | 30450 | Rhinoplasty, secondary; major revision (nasal tip work and osteotomies) |
| | 31587 | Laryngoplasty, cricoid split, without graft placement |
| | 31599 | Unlisted procedure, larynx |
| | 31750 | Tracheoplasty; cervical |
| | 55970 | Intersex surgery; male to female |
| | 55980 | Intersex surgery; female to male |
| | 56805 | Clitoroplasty for intersex state |
| | 57291 | Construction of artificial vagina; without graft |
| | 57292 | Construction of artificial vagina; with graft |
| | 57335 | Vaginoplasty for intersex state |
| | 66683 | Implantation of iris prosthesis, including suture fixation and repair or removal of iris, when performed ***(Code effective 1/1/2025)*** |
| | 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<br>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 |
| 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 |

| Effective Date | Action |
|---|---|
| 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. |

## Definitions of Decision Determinations

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

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

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

## Prior Authorization Requirements (as applicable to your plan)

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

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

We are 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.

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

*Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.*

## Appendix A

| POLICY STATEMENT | |
|---|---|
| **BEFORE**<br>Red font: Verbiage removed | **AFTER** |
| **Reconstructive Services BSC7.08**<br><br>**Policy Statement:**<br>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:<br>• Create a normal appearance to the extent possible<br>• Improve function<br><br>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:<br>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<br>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)<br>C. There is alternative approved medical or surgical intervention with equal or superior clinical outcomes<br>D. The procedure is for cosmetic purposes only<br><br>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**. | **Reconstructive Services BSC7.08**<br><br>**Policy Statement:**<br><br>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:<br>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<br>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)<br>C. There is alternative approved medical or surgical intervention with equal or superior clinical outcomes<br>D. The procedure is for cosmetic purposes only<br><br>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**. |