

COSMETIC SURGERY

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I. POLICY STATEMENT

PEHP excludes coverage of cosmetic procedures and surgery that are not medically necessary. However, some procedures that would otherwise be considered cosmetic surgery may be covered when the surgery is needed to improve the functioning of a body part even if the surgery also improves or changes the appearance of a portion of the body. Additionally, PEHP may also cover otherwise cosmetic surgery if required by law (e.g., surgery to correct the result of an injury, breast reconstruction following lumpectomy or mastectomy, surgery needed to treat certain congenital defects such as cleft lip or cleft palate).

Please note that, while this policy statement addresses many common procedures, it does not address all procedures that might be considered to be cosmetic surgery excluded from coverage. PEHP reserves the right to deny coverage for surgery and procedures that are cosmetic but not listed in this policy.

A. PEHP Master Policy Definitions:

1. **Cosmetic Procedure / Surgery:** Any procedure performed to improve appearance or to correct a deformity without restoring a physical bodily function.
2. **Reconstructive Procedure / Surgery:** Non-cosmetic surgery / procedure performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, which restores bodily function.

II. MEDICAL NECESSITY DETERMINATION

A. Non-Cosmetic / Reconstructive Procedures and Surgeries:

1. PEHP may consider the following procedures and surgeries medically necessary when coverage criterion is met (*may not be an all-inclusive list*). Coverage of the following procedures may also vary depending on the employer group and the diagnosis. The requesting provider may be required to submit documentation, including photographs, letters of medical necessity, medical records, etc.:
 - a. Acrochordon, or skin tag (a small, benign [non-cancerous] skin growth that typically appears as a soft, raised bump with a narrow stalk), Removal
 - 1) Skin tag removal may be considered medically necessary when it is located in an area of friction with documentation of repeated irritation and bleeding.
 - b. Actinic Keratoses (precancerous skin lesions skin lesions caused by prolonged exposure to ultraviolet (UV) radiation from the sun or artificial sources) Treatment
 - 1) For treatment coverage criterion see PEHP Clinical Policies "Actinic Keratoses Treatments" and "Pulsed Dye Laser Treatment".
 - c. Autologous Fat Grafting in Breast Reconstruction
 - 1) Autologous fat grafting (a surgical procedure where fat tissue is harvested from one area of the body and transferred to another area to enhance volume, shape, or restore tissue) harvested by liposuction technique may be considered medically necessary in conjunction with an eligible breast reconstruction surgery.
 - 2) For coverage criterion see PEHP Clinical Policy "Breast Reconstruction Following Mastectomy or Lumpectomy".
 - d. Blepharoplasty (a surgical procedure that removes excess skin, fat, and muscle from the upper and/or lower eyelids).
 - 1) For coverage criterion see PEHP Clinical Policy "Eyelid Surgery".

- e. Breast Reconstruction / Reduction Mammoplasty (breast reduction)
 - 1) For coverage criterion see PEHP Clinical Policies "Breast Reconstruction Following Mastectomy or Lumpectomy" , "Gender Reassignment Surgical Benefit", and "Reduction Mammoplasty".
- f. Collagen Implants
 - 1) Collagen (a protein that is naturally found in the skin, bones, and connective tissues that can be used to restore volume, improve skin texture, and correct structural defects) implants may be considered medically necessary for the treatment of urinary incontinence.
 - a) For coverage criterion see PEHP Clinical Policy "Urinary Incontinence and Ureterovesicular Reflux".
 - 2) Collagen implants are considered cosmetic for all other indications.
- g. Electrolysis or Laser Hair Removal
 - 1) For coverage criterion see PEHP Clinical Policy "Gender Reassignment Surgical Benefit".
 - 2) Please be aware that coverage for gender reassignment surgery may vary depending on the employer group.
- h. Gender Reassignment Surgery
 - 1) For coverage criterion see PEHP Clinical Policy "Gender Reassignment Surgical Benefit".
- i. Implantation / Attachment of a Prosthesis
 - 1) The following prostheses may be considered medically necessary when selection criterion is met:
 - a) Breast prostheses (implants). See PEHP Clinical Policies "Breast Reconstruction Following Mastectomy or Lumpectomy" and "Gender Reassignment Surgical Benefit" for coverage criterion.
 - b) Definitive obturator prosthesis. See PEHP Clinical Policies "Dental Services and Oral and Maxillofacial Surgery" and "Temporomandibular Joint Syndrome (TMJ) and Disorders (TMD)" for coverage criterion.
 - c) Ear (auricular) prostheses
 - d) Eye (ocular) prostheses
 - e) Facial prosthesis. See PEHP Clinical Policies "Dental Services and Oral and Maxillofacial Surgery" and "Orthognathic Surgery" for coverage criterion.
 - f) Interim obturator prosthesis. See PEHP Clinical Policies "Dental Services and Oral and Maxillofacial Surgery" and "Temporomandibular Joint Syndrome (TMJ) and Disorders (TMD)" for coverage criterion.
 - g) Mandibular resection prosthesis. See PEHP Clinical Policies "Dental Services and Oral and Maxillofacial Surgery" and "Temporomandibular Joint Syndrome (TMJ) and Disorders (TMD)" for coverage criterion.
 - h) Nasal prosthesis. See PEHP Clinical Policy "Dental Services and Oral and Maxillofacial Surgery" for coverage criterion.
 - i) Oral surgical prosthesis. See PEHP Clinical Policies "Dental Services and Oral and Maxillofacial Surgery", "Orthognathic Surgery", and "Temporomandibular Joint Syndrome (TMJ) and Disorders (TMD)" for coverage criterion.
 - j) Orbital prosthesis. See PEHP Clinical Policy "Dental Services and Oral and Maxillofacial Surgery" for coverage criterion.
 - k) Palatal augmentation prosthesis. See PEHP Clinical Policy "Dental Services and Oral and Maxillofacial Surgery" for coverage criterion.
 - l) Palatal lift prosthesis. See PEHP Clinical Policies "Dental Services and Oral and Maxillofacial Surgery" and "Orthognathic Surgery" for coverage criterion.
 - m) Speech aid prosthesis. See PEHP Clinical Policies "Dental Services and Oral and Maxillofacial Surgery" and "Orthognathic Surgery" for coverage criterion.
 - n) Testicular prosthesis. See PEHP Clinical Policies "Gender Reassignment Surgical Benefit" for coverage criterion.
- j. Keloid Removal
 - 1) Keloid (an overgrown, raised scar that forms after an injury or skin trauma; also known as hypertrophic scars) removal may be considered medically necessary if the criteria below is met:
 - a) There is documentation in the medical records that the keloid is causing significant functional impairment and/or pain; and
 - b) Keloid removal is expected to improve the functional impairment and/or pain.
 - 2) Keloid removal is considered cosmetic and not medically necessary when performed in the absence of a significant functional impairment or pain, is not reconstructive, and is intended to change a physical appearance that would be considered within normal variation in anatomy.
 - 3) See PEHP Clinical Policies "Carbon Dioxide Laser for Actinic Lesions and Other Selected Indications", "Pulsed Dye Laser Treatment", and "Radiation Therapy" for other keloid treatments.
- k. Lipoma Removal
 - 1) Excision (surgical removal) of a lipoma (a benign [non-cancerous] tumor made up of fat cells) may be considered medically necessary if the lipoma(s) is tender and hinders the member's ability to perform daily activities due to the location of the lipoma(s) on body parts that are affected by constant touch and/or pressure.
- l. Liposuction, or Suction Lipectomy (a surgery that uses suction to remove fat from specific areas of the body)
 - 1) For coverage criterion see PEHP Clinical Policy "Lipedema Treatment".

- 2) Liposuction is a PEHP Master Policy exclusion for indications other than lipedema, unless shown by clear and convincing medical evidence as determined solely by PEHP to be performed for non-cosmetic reasons.
- m. Lobuloplasty (Earlobe Repair)
 - 1) Lobuloplasty (a surgical procedure that repairs and reshapes the earlobe), or earlobe repair, may be considered medically necessary as a result of a traumatic injury (e.g., tear or split in the earlobe).
 - 2) Lobuloplasty, or earlobe repair to close a stretched pierce hole, in the absence of a traumatic injury, is considered cosmetic and, therefore, is not covered.
- n. Macrodactyly (abnormally large finger or toe) Repair
 - 1) Macrodactyly repair may be considered medically necessary when the enlarged finger or toe is causing significant hand and/or foot functional impairment and/or pain due to its size.
- o. Orthognathic (Jaw) Surgery
 - 1) For coverage criterion see PEHP Clinical Policy "Orthognathic Surgery".
 - 2) Orthodontic treatment or expansion appliance in conjunction with jaw surgery is a PEHP Master Policy exclusion.
- p. Panniculectomy (a surgical procedure that removes excess skin and fat from the lower abdomen, also known as the "panniculus".)
 - 1) For coverage criterion see PEHP Clinical Policy "Panniculectomy, Abdominoplasty and Lipectomy".
- q. Pulsed-Dye Laser Treatment (PDLT) (concentrated beam of light that targets blood vessels in the skin)
 - 1) For coverage criterion see PEHP Clinical Policy "Pulsed Dye Laser Treatment".
- r. Reconstruction of the External Auditory Canal
 - 1) Reconstruction of the external auditory canal may be considered medically necessary for functional deficiencies resulting from a congenital defect (e.g., anotia [total absence of the external ear and auditory canal], aural atresia [absence of the ear canal], microtia [small, abnormally shaped or absent external ears]), burns, disease, surgery, tumor, or trauma when performed to restore hearing function.
- s. Rhinophyma Excision or Shaving
 - 1) Excision or shaving of rhinophyma (a skin disorder that causes the nose to enlarge and become red, bumpy, and bulbous) may be considered medically necessary for the treatment of bleeding or infection that is refractory to medical therapy (i.e. the need for repeated cautery of bleeding telangiectasias [small, dilated blood vessels that appear as red, blue, or purple lines on the skin] or frequent courses of antibiotics for pustular eruptions).
 - 2) Excision or shaving of rhinophyma is considered cosmetic for all other indications.
- t. Rhinoplasty (surgery to change size, shape, and/or proportions of the nose) for selected conditions only.
 - 1) For coverage criterion see PEHP Clinical Policy "Septoplasty and Rhinoplasty".
- u. Scar Revision
 - 1) Scar revision, or repair, may be considered medically necessary when the criteria below is met:
 - a) There is documentation in the medical records that the scar (i.e., as a result from an eligible surgery, therapeutic procedure, or accidental injury) is causing significant functional impairment and/or pain; and
 - b) Scar revision is expected to improve the functional impairment and/or pain.
 - 2) Scar revision is considered cosmetic and not medically necessary when performed in the absence of a significant functional impairment or pain, is not reconstructive, and is intended to change a physical appearance that would be considered within normal variation in anatomy.
- v. Septoplasty (surgery that corrects a deviated nasal septum)
 - 1) For coverage criterion see PEHP Clinical Policy "Septoplasty and Rhinoplasty".
- w. Tattoos
 - 1) Tattooing may be considered medically necessary in conjunction with an eligible breast reconstructive surgery. For coverage criterion see PEHP Clinical Policy "Breast Reconstruction Following Mastectomy or Lumpectomy".
 - 2) Radiation therapy tattooing is also considered medically necessary, but the fee is included within the overall radiation therapy planning and delivery.
- x. Ventral hernia (a condition where part of the intestine or other abdominal organs protrude through a weakness if the front abdominal muscles) Repair
 - 1) For coverage criterion see PEHP Clinical Policy "Panniculectomy, Abdominoplasty and Lipectomy"
- y. Vulvectomy/Partial Vulvectomy
 - 1) Vulvectomy/partial vulvectomy (a surgical procedure that involves the removal of part or all of the vulva, which is the entire external female genital area, including the labia majora, labia minora, clitoris, and vaginal opening) may be considered medically necessary for the treatment of premalignant (pre-cancer) or malignant (cancer) lesions and for diagnostic excisional biopsies. This procedure may also involve removal of lymph nodes and tissue in the groin area.
 - 2) See PEHP Clinical Policy "Gender Reassignment Surgical Benefit" for coverage criterion for vulvectomy in conjunction with gender reassignment surgery.
 - 3) Vulvectomy/partial vulvectomy is not covered for any other indication, including cosmetic indications or when vulvar tissue interferes with sexual intercourse, clothing, exercise, or other recreational activities.

- 4) **Note:** A partial vulvectomy is not the same as a labiaplasty. A partial vulvectomy is a more extensive procedure where part of the vulva is removed with a medical purpose (e.g., treating cancerous or precancerous lesions) while a labiaplasty is a simpler cosmetic procedure that aims to reshape or reduce the size of the labia minora primarily for aesthetic reasons.

B. Non-Covered Cosmetic Procedures and Surgeries:

PEHP considers any procedure, service, or surgery that is primarily for cosmetic purposes to improve or change appearance or to correct a deformity without restoring a physical bodily function is excluded from coverage including, but not limited to:

1. Abdominoplasty is a PEHP Master Policy exclusion.
2. Aesthetic operations on umbilicus
3. Brachioplasty (arm lift)
4. Breast reconstruction surgery using autologous fat transfer, or augmentation or implants solely for cosmetic purposes is a PEHP Master Policy exclusion unless allowed under federal law (WHCRA/The Women's Health and Cancer Rights Act). See PEHP Clinical Policy "Breast Reconstruction Following Mastectomy or Lumpectomy" for exceptions.
5. Breast lift (mastopexy). See PEHP Clinical Policy "Breast Reconstruction Following Mastectomy or Lumpectomy" for exceptions.
6. Buttock, or gluteal, lift or augmentation
7. Capsulotomy, replacement, removal or repair of breast implant originally placed for cosmetic purposes or any other complication(s) of cosmetic or non-covered breast surgery is a PEHP Master Policy exclusion.
8. Chemical peels and exfoliation regardless of the indication is a PEHP Master Policy exclusion.
9. Cheek implant (malar implant/augmentation)
10. Chin implant, genioplasty, mentoplasty, and horizontal symphyseal osteotomy are a PEHP Master Policy exclusion.
11. Correction of inverted nipple
12. Dermabrasion (a method of controlled surgical scraping of the skin) regardless of the indication is a Master Policy exclusion.
13. Dermal injections of FDA-approved fillers (e.g., poly-L-lactic acid dermal injection [Sculptra] or calcium hydroxyapatite dermal injection [Radiesse]) for HIV lipoatrophy for treating facial lipodystrophy syndrome due to antiretroviral therapy in HIV-infected persons.
14. Ear or body piercing
15. Electrolysis or laser hair removal. See PEHP Clinical Policy "Gender Reassignment Surgical Benefit" for possible exceptions.
16. Excision of excessive skin of thigh (thigh lift, thighplasty), leg, hip, buttock, arm (arm lift, brachioplasty), forearm or hand, submental fat pad, or other areas.
17. Facial rejuvenation/plumping/collagen or fat injections
18. Gender reassignment surgery unless otherwise allowed by an employer group is a PEHP Master Policy exclusion.
19. Genitalia procedures to improve and/or enhance the appearance or sexual performance of, including the following procedures (*may not be an all-inclusive list*):
 - a. Clitoral reduction
 - b. Designer vaginoplasty
 - c. Hymenoplasty
 - d. G-spot amplification
 - e. Labia majora surgery/reshaping
 - f. Labiaplasty
 - g. Pubic liposuction or lift
 - h. Reduction of labia minora
 - i. Re-virgination
 - j. Vaginal rejuvenation
 - k. Vaginal tightening
 - l. Vulvar reconstruction
20. Hair transplants or other treatment for hair loss or restoration is a PEHP Master Policy exclusion.
21. Injection of collagen. See PEHP Clinical Policy "Urinary Incontinence and Ureterovesicular Reflux" for exceptions.
22. Lacrimal gland resuspension for lacrimal gland prolapsed
23. Laser resurfacing for wrinkling or aging skin.
24. Lipectomy (a surgical procedure that involves removing excess fat and skin from specific areas of the body) is a PEHP Master Policy exclusion.
25. Lipoabdominoplasty
26. Liposuction is a PEHP Master Policy exclusion, unless shown by clear and convincing medical evidence as determined solely by PEHP to be performed for non-cosmetic reasons.
 - a. See PEHP Clinical Policies "Breast Reconstruction Following Mastectomy or Lumpectomy" and "Lipedema Treatment" for exceptions.
27. Mastectomy for gynecomastia is a PEHP Master Policy exclusion.

28. Mesotherapy (injection of various substances into the tissue beneath the skin to sculpt body contours by lysing subcutaneous fat)
29. Neck Tucks
30. Otoplasty (a surgical procedure that reshapes, repositions, or reduces the size of the external ear [auricle]) is a PEHP Master Policy exclusion.
31. Panniculectomy. See PEHP Clinical Policy "Panniculectomy, Abdominoplasty and Lipectomy" for exceptions.
32. Removal of frown lines
33. Removal of spider angiomas
34. Removal of supernumerary nipples (polymastia)
35. Repair or correction of diastasis recti is a PEHP Master Policy exclusion.
36. Rhytidectomy (including meloplasty, face lift) is a PEHP Master Policy exclusion.
37. Salabrasion
38. Surgery to correct "moon face" (side effect of cortisone therapy)
39. Surgery or procedures that are related to teeth (e.g., gum reshaping, veneers, teeth whitening)
40. Surgery to correct tuberous breast deformity (a type of breast deformity characterized by a narrow, conical shape with a prominent nipple and areola)
41. Surgical depigmentation (e.g., laser treatment) of nevus of Ito or Ota (benign, blue or gray patches of hyperpigmentation that are caused by melanocytes)
42. Tattoo removal
43. Thigh lifts
44. Treatment with small gel-particle hyaluronic acid (e.g., Restylane) and large gel-particle hyaluronic acid (e.g., Perlane) to improve the skin's contour and/or reduce depressions due to acne, injury, scars, or wrinkles
45. Treatment of spider or reticular veins is a PEHP Master Policy exclusion.

III. RELATED CLINICAL POLICIES

- A. The following PEHP clinical policies address other procedures that may be considered cosmetic if performed primarily for cosmetic purposes:

1. Actinic Keratoses Treatments
2. Bariatric Surgery Guidelines
3. Breast Implant Removal
4. Breast Reconstruction Following Mastectomy or Lumpectomy
5. Carbon Dioxide Laser for Actinic Lesions and Other Selected Indications
6. Eyelid Surgery
7. Gender Reassignment Surgery
8. Graves' Ophthalmopathy Treatments
9. Gynecomastia Surgery
10. Lipedema Treatment
11. Lymphedema - Diagnosis and Treatment
12. Orthognathic Surgery
13. Panniculectomy, Abdominoplasty and Lipectomy
14. Pectus Excavatum and Poland's Syndrome
15. Phototherapy and Photochemotherapy (PUVA) for Skin Conditions
16. Prophylactic Mastectomy
17. Pulsed Dye Laser Treatment
18. Radiation Therapy
19. Reduction Mammoplasty
20. Septoplasty and Rhinoplasty
21. Temporomandibular Joint Syndrome (TMJ) and Temporomandibular Disorders (TMD)
22. Urinary Incontinence and Ureterovesicular Reflux
23. Varicose Veins
24. Vision Surgery and Vision Screening for Medical Diseases or Injury

IV. CODES

- A. This list of codes may not be all-inclusive because the CPT, HCPCS, and ICD-10 coding for a majority of the procedures listed in this clinical policy are addressed in separate clinical policies specific to the procedure and the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) code updates may occur more frequently than policy updates.
- B. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

CPT codes COVERED if selection criteria are met:	
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions [not covered for more than 15 lesions and billed with +11201]
11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional ten lesions (List separately in addition to code for primary procedure)
11300 - 11313	Shaving of epidermal or dermal lesions
11400 - 11446	Excision of benign lesions
11920 - 11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation
11950 - 11951	Subcutaneous injection of filling material (e.g., collagen)
11952 - 11954	Subcutaneous injection of filling material (e.g., silicone)
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.5 cm or less
12031 - 13153	Repair, intermediate complex
12051	Layer closure of wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.5 cm or less
15220 - 15221	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g. fat, dermis, fascia)
15771-15774	Grafting of autologous fat harvested by liposuction technique
15820 - 15823	Blepharoplasty
15840 - 15845	Graft for facial nerve paralysis
17106 - 17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique)
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
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions. <i>[Not covered for supernumerary nipples (Q83.3)]</i>
19318 - 19350, 19357 - 19396	Repair and/or reconstruction of breast [except breast lift (mastopexy)] [not covered to repair tuberous breast deformity]
21740 - 21743	Reconstructive repair of pectus excavatum or carinatum
26590	Repair macrodactyly, each digit
30120	Excision or surgical planning of skin of nose for rhinophyma
30150	Rhinectomy; partial
30160	Rhinectomy; total
30420, 30435, 30450, 30460, 30462	Rhinoplasty
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
37785	Ligation, division, and/or excision of varicose vein cluster(s), one leg
40500	Vermilionectomy (lip shave), with mucosal advancement
40510	Excision of lip; transverse wedge excision with primary closure
40520	Excision of lip; V-excision with primary direct linear closure
40525	Excision of lip; full thickness, reconstruction with local flap (e.g., Estlander or fan)
40527	Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)
40530	Resection of lip, more than one-fourth, without reconstruction
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck
56620	Vulvectomy simple; partial <i>*Not covered for cosmetic indications, including labiaplasty, or when vulvar tissue interferes with sexual intercourse, clothing, exercise, or other recreational activities.</i>
56630 - 56640	Vulvectomy, radical
67901 - 67909	Repair of brow ptosis or blepharoptosis

69310	Reconstruction of external auditory canal (meatoplasty) (e.g., for stenosis due to injury, infection) (separate procedure)
69320	Reconstruction of the external auditory canal for congenital atresia, single stage
HCPCS codes COVERED if selection criteria are met:	
L8010	Breast prosthesis, mastectomy sleeve
L8020	Breast prosthesis, mastectomy form
L8030	Breast prosthesis, silicone or equal, without integral adhesive
L8035	Custom breast prosthesis, post mastectomy, molded to patient model
L8039	Breast prosthesis, not otherwise specified
L8040	Nasal prosthesis, provided by a non-physician
L8041	Midfacial prosthesis, provided by a non-physician
L8042	Orbital prosthesis, provided by a non-physician
L8043	Upper facial prosthesis, provided by a non-physician
L8044	Hemi-facial prosthesis, provided by a non-physician
L8045	Auricular prosthesis, provided by a non-physician
L8046	Partial facial prosthesis, provided by a non-physician
L8047	Nasal septal prosthesis, provided by a nonphysician
L8048	Unspecified maxillofacial prosthesis, provided by a non-physician
L8049	Repair or modification of maxillofacial prosthesis, provided by a non-physician
L8600	Implantable breast prosthesis, silicone or equal
L8603	Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies
L8610	Ocular implant
Q3031	Collagen skin test
V2623	Prosthetic eye
V2624	Polishing/resurfacing of ocular prosthesis
V2625	Enlargement of ocular prosthesis
V2626	Reduction of ocular prosthesis
V2627	Scleral cover shell
V2628	Fabrication and fitting of ocular conformer
V2629	Prosthetic eye, other type
ICD- 10 codes COVERED if selection criteria are met:	
C00.0 - D49.9	Neoplasms [not covered for nevi of Ota and Ito]
L57.0	Actinic keratosis
L71.1	Rhinophyma
L74.510 - L74.519	Primary focal hyperhidrosis
L90.5	Scar conditions and fibrosis of skin
L91.0	Hypertrophic scar [Keloid scar]
L91.8	Other hypertrophic disorders of the skin [wrinkling of skin]
N36.8	Other specified disorders of urethra
N39.3 - N39.9	Urinary incontinence
N39.41 - N39.49, R32	Urinary incontinence
N60.11 - N60.19	Diffuse cystic mastopathy
Q16.0 - Q16.9	Congenital malformations of ear causing impairment of hearing [includes aural atresia]
Q17.2 - Q17.23	Microtia
Q36.0 - Q36.9	Cleft lip
Q82.5	Congenital non-neoplastic nevus
S01.501+ - S01.512+	Unspecified open wound of lip and oral cavity
S01.531+ - S01.552+	Puncture wound of lip and oral cavity without foreign body
S01.90x+ - S01.95x+	Open wound of unspecified part of head
S02.2xx+ - S02.2xx+	Fracture of nasal bones

S09.8xx+ - S09.93x+	Other specified injuries of head
T33.011+ - T34.99x+	Superficial frostbite and frostbite with tissue necrosis
Z85.3	Personal history of malignant neoplasm of breast
Z90.10 - Z90.13	Acquired absence of breast
CPT codes NOT COVERED for indications listed in the policy (<i>may not be an all-inclusive list</i>):	
0419T	Destruction neurofibroma, extensive, (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibroma
0420T	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); trunk and extremities, extensive, greater than 100 neurofibromas
0437T	Implantation of non-biologic or synthetic implant (e.g., polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)
11950 – 11951	Subcutaneous injection of filling material (e.g., collagen)
15775 - 15776	Punch graft for hair transplant
15780, 15781, 15782	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis); segmental, face; or regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15786 - 15787	Abrasion; single lesion (e.g., keratosis, scar); each additional four lesions or less (List separately in addition to code for primary procedure) [not covered for asymptomatic keloids]
15788, 15789, 15793	Chemical peel
15824 - 15829	Rhytidectomy
15830	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen infraumbilical panniculectomy
15832 - 15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy, thigh, leg, hip, buttock, arm, forearm or hand, submental fat pad, or other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g. abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy, head and neck
15877	Suction assisted lipectomy; trunk
15878 - 15879	Suction assisted lipectomy; upper and lower extremity
17360	Chemical exfoliation for acne (e.g., acne paste, acid)
17380	Electrolysis epilation, each 30 minutes
19300	Mastectomy for gynecomastia
19316	Mastopexy
19355	Correction of inverted nipples
21120 - 21123	Genioplasty
21125 - 21127	Augmentation, mandibular body or angle; prosthetic material or with bone graft, onlay or interpositional (includes obtaining autograft)
21137 - 21139	Reduction forehead
21270	Malar augmentation, prosthetic material
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
30400 - 30410	Rhinoplasty, primary
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
31830	Revision of tracheostomy scar
49560 - 49561	Repair initial incisional or ventral hernia; reducible, incarcerated or strangulated
49565 - 49566	Repair recurrent incisional or ventral hernia; reducible, incarcerated or strangulated
49568	Implantation of mesh or other prosthesis for incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)
54660	Insertion of testicular prosthesis (separate procedure)
56800	Plastic repair of introitus [not covered for cosmetic indications]
56805	Clitoroplasty for intersex state [not covered for cosmetic indications]

57291 - 57292	Construction of artificial vagina; without or with graft [not covered for cosmetic indications]
57335	Vaginoplasty for intersex state [not covered for cosmetic indications]
69090	Ear piercing
69300	Otoplasty, protruding ear, with or without size reduction
HCPCS codes NOT COVERED for indications listed in the policy (<i>may not be an all-inclusive list</i>):	
D5919	Facial prosthesis
D5925	Facial augmentation implant prosthesis
G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)
L8000	Breast prostheses mastectomy bra
L8001	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral, any size, any type
L8002	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral, any size, any type
L8015	External breast prosthesis garment, with mastectomy form, post mastectomy
Q2026	Injection, Radiesse, 0.1 ml
Q2028	Injection, sculptra, 0.5 mg
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes
ICD- 10 codes NOT COVERED for indications listed in the policy (<i>may not be an all-inclusive list</i>):	
B20	Human immunodeficiency virus [HIV] disease
E88.1	Lipodystrophy, not elsewhere classified
L68.0 - L68.9	Hirsutism
L70.0 - L70.9	Acne
M04.1 - M04.9	Auto inflammatory syndromes
M35.00 - M35.9	Other systemic involvement of connective tissue [autoimmune disease]
M62.08	Separation of muscle (nontraumatic), other site [diastasis recti]
N64.59	Other signs and symptoms in breast [inverted nipple]
N90.60 - N90.69	Hypertrophy of vulva
O92.011 - O92.03	Retracted nipple associated with pregnancy, the puerperium, and lactation
O92.20 - O92.29	Other and unspecified disorders of breast associated with pregnancy and the puerperium [inverted nipple]
Q67.7	Pectus carinatum
Q83.3	Accessory nipple [supernumerary nipple]
Z21	Asymptomatic human immunodeficiency virus [HIV] infection status [HIV] infection status