Medical Policy:
Cosmetic and Reconstructive Surgery Procedures (Commercial)

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
MG.MM.ME.67	3/14/2025	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

 The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

Overview

ConnectiCare regards the surgical procedures listed in the Applicable Coding Table(s) as cosmetic (unless substantiating documentation is received that would otherwise indicate that the purpose of the procedure is to restore or improve bodily function or is otherwise medically necessary).

The plan reserves the right to deny coverage for other procedures that are cosmetic and not medically necessary.

Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. Please check benefit plan descriptions for details. If there is a discrepancy between this policy and a member's plan of benefits, then the provision of the benefits will prevail.

Indications for Coverage

For plans that include benefits for the procedures listed below, the following are eligible for coverage as reconstructive and medically necessary when **all of** the following criteria are met:

- There is documentation that the physical abnormality and/or physiological abnormality is causing a functional impairment that requires correction; and
- The proposed treatment is of proven efficacy and is deemed likely to significantly improve or restore the patient's physiological function.

Limitations/Exclusions

The Plan does not cover cosmetic procedures under the following circumstances, *including but not limited to*:

- Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function (i.e., procedures that do not meet the reconstructive criteria in the Indications for Coverage section).
- Pharmacological regimens, nutritional procedures, or treatments.
- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
- Skin abrasion procedures performed as a treatment for acne.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider or varicose veins outside of varicose vein medical policy.
- Ancillary services related to cosmetic procedures that are not considered medically necessary.
- Hair removal or replacement by any means (except when performed in conjunction with approved services pertaining to gender dysphoria).

Applicable Coding Table(s)

- Table 1: Medical procedures deemed always cosmetic
- Table 2: Medical procedures that may be cosmetic (review may be required to determine if the service is cosmetic or reconstructive)

Table 1: Procedure codes deemed always cosmetic

Code	Description
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)
11950	Subcutaneous injection of filling material (eg, collagen) *Exception: NY and Mass HIV-related lipodystrophy mandate*
11951	Subcutaneous injection of filling material (eg, collagen) *Exception: NY and Mass HIV-related lipodystrophy mandate*
11952	Subcutaneous injection of filling material (eg, collagen) *Exception: NY and Mass HIV-related lipodystrophy mandate*

Code	Description
11954	Subcutaneous injection of filling material (eg, collagen) *Exception: NY and Mass HIV-related lipodystrophy mandate*
15775	Punch graft for hair transplant
15776	Punch graft for hair transplant: more than 15 punch grafts
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
~~**15819**~~ **Code del. 1/1/2025**	~~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
17340	Cryotherapy (CO_2 slush, liquid N_2) for acne
17360	Chemical exfoliation for acne (eg, acne paste, acid)
17380	Electrolysis epilation, each 30 minutes *Exception, see Gender Affirming Medical Policy*
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)

Code	Description
19355	Correction of inverted nipples
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
65760	Keratomileusis
65765	Keratophakia
65767	Epikeratoplasty
65771	Radial keratotomy
69090	Ear piercing
69300	Otoplasty, protruding ear, with or without size reduction
96902	Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality
S0800	Laser in situ keratomileusis (LASIK)
S0810	Photorefractive keratectomy (PRK)
S0812	Phototherapeutic keratectomy (PTK)
S0596	Phakic intraocular lens for correction of refractive error

Table 2: Procedure codes generally deemed cosmetic (review may be required to determine if the service is cosmetic or reconstructive)

Code	Description	Comments/Related Medical Policies
10040	Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation	Breast Implants and Reconstruction Gender Affirming Surgery
11921	Tattooing, intradermal introduction	Breast Implants and Reconstruction Gender Affirming Surgery
11922	Tattooing, intradermal introduction	Breast Implants and Reconstruction Gender Affirming Surgery

Code	Description	Comments/Related Medical Policies
11960	Insertion of tissue expander(s) **for other than breast**, including subsequent expansion	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
11971	Removal of tissue expander(s) without insertion of prosthesis	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage Also applicable — MCG General Surgery or Procedure GRG (SG-GS)
15730	Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)	May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage Also applicable — MCG Wound and Skin Management GRG (PG-WS)
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)	May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage Also applicable — MCG Wound and Skin Management GRG (PG-WS)
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage Breast Implants and Reconstruction
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage Breast Implants and Reconstruction
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage Breast Implants and Reconstruction
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage

Code	Description	Comments/Related Medical Policies
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	Dermabrasion
15781	Dermabrasion; segmental, face	Dermabrasion
15782	Dermabrasion; regional, other than face	Dermabrasion
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	Dermabrasion
15788	Chemical peel, facial; epidermal	Chemical Peels
15789	Chemical peel, facial; dermal	Chemical Peels
15792	Chemical peel, nonfacial; epidermal	Chemical Peels
15793	Chemical peel, nonfacial; dermal	Chemical Peels
15820	Blepharoplasty, lower eyelid;	Blepharoplasty
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	Blepharoplasty
15822	Blepharoplasty, upper eyelid;	Blepharoplasty
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	Blepharoplasty
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	Abdominoplasty/Panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	Abdominoplasty/Panniculectomy
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Pulse Dye Laser Therapy for Cutaneous Vascular Lesions
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Pulse Dye Laser Therapy for Cutaneous Vascular Lesions
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Pulse Dye Laser Therapy for Cutaneous Vascular Lesions

Code	Description	Comments/Related Medical Policies
17380	Electrolysis epilation, each 30 minutes	Considered always cosmetic *except in conjunction with gender affirming/reassignment.* Gender Affirming Surgery
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	Medical records required for review of unlisted codes
19300	Mastectomy for gynecomastia	MCG #A-0273 Mastectomy for Gynecomastia
19316	Mastopexy	Breast Implants and Reconstruction Breast Reduction Mammoplasty
19318	Reduction mammaplasty	Breast Reduction Mammoplasty Gender Affirming Surgery
19325	Mammaplasty, augmentation; with prosthetic implant	Breast Implants and Reconstruction
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction (unless diagnosis of breast cancer is reported)	Breast Implants and Reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction (unless diagnosis of breast cancer is reported)	Breast Implants and Reconstruction
21086	Impression and custom preparation; auricular prosthesis	May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21087	Impression and custom preparation; nasal prosthesis	May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21137	Reduction forehead; contouring only	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage

Code	Description	Comments/Related Medical Policies
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21181	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage

Code	Description	Comments/Related Medical Policies
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21242	Arthroplasty, temporomandibular joint, with allograft	Orthognathic Surgery
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	MCG #A-0523 Temporomandibular Joint Arthroplasty
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21275	Secondary revision of orbitocraniofacial reconstruction	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage

Code	Description	Comments/Related Medical Policies
21280	Medial canthopexy (separate procedure)	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21282	Lateral canthopexy	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
21740	Reconstructive repair of pectus excavatum or carinatum; open	Surgical Correction of Chest Wall Deformities
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy	Surgical Correction of Chest Wall Deformities
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy	Surgical Correction of Chest Wall Deformities
28344	Reconstruction, toe(s); polydactyly	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	Rhinoplasty
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	Rhinoplasty
30420	Rhinoplasty, primary; including major septal repair	Rhinoplasty
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	Rhinoplasty
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	Rhinoplasty
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	Rhinoplasty
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	Rhinoplasty
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies	Rhinoplasty

Code	Description	Comments/Related Medical Policies
30540	Repair choanal atresia; intranasal	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
30545	Repair choanal atresia; transpalatine	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
30560	Lysis intranasal synechia	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
36468	Injection of sclerosant for spider veins (telangiectasia), limb or trunk	See Varicose Vein Treatment Limitations and Exclusions Varicose Vein Treatment
36469	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face	See Varicose Vein Treatment Limitations and Exclusions Varicose Vein Treatment
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	See Varicose Vein Treatment Limitations and Exclusions Varicose Vein Treatment
36471	Injection of sclerosing solution sclerosant; multiple incompetent veins, (other than telangiectasia), same leg	See Varicose Vein Treatment Limitations and Exclusions Varicose Vein Treatment
40500	Vermilionectomy (lip shave), with mucosal advancement	May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
55970	Intersex surgery; male to female	Gender Affirming Surgery
55980	Intersex surgery; female to male	Gender Affirming Surgery
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	Blepharoplasty

Code	Description	Comments/Related Medical Policies
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	Blepharoplasty
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	Blepharoplasty
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	Blepharoplasty
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	Blepharoplasty
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	Blepharoplasty
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)	Blepharoplasty
67909	Reduction of overcorrection of ptosis	Blepharoplasty
67911	Correction of lid retraction	Blepharoplasty
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)	Blepharoplasty
67914	Repair of ectropion; suture	Blepharoplasty
67915	Repair of ectropion; thermocauterization	Blepharoplasty
67916	Repair of ectropion; excision tarsal wedge	Blepharoplasty
67917	Repair of ectropion; extensive (eg, tarsal strip operations)	Blepharoplasty
67921	Repair of entropion; suture	Blepharoplasty
67922	Repair of entropion; thermocauterization	Blepharoplasty
67923	Repair of entropion; excision tarsal wedge	Blepharoplasty
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)	Blepharoplasty
67950	Canthoplasty (reconstruction of canthus)	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
67961	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage

Code	Description	Comments/Related Medical Policies
67966	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin	Medical record review required. May be considered medically necessary when causing significant impairment of physical or mechanical function. See Indications for Coverage
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	Phototherapy, Photochemotherapy and Photodynamic Therapy for Dermatologic Conditions
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least four to eight hours of care under direct supervision of the physician (includes application of medication and dressings)	Phototherapy, Photochemotherapy and Photodynamic Therapy for Dermatologic Conditions

Definitions

Cosmetic surgery	Cosmetic surgery procedures are those intended solely to refine or reshape structures or surfaces that are not functionally impaired. They are performed to improve appearance or self-esteem, or for other psychological, psychiatric, or emotional reasons. Cosmetic surgery is differentiated from reconstructive surgery, which is generally designed to improve function, but will usually include an improvement in appearance of the body area involved. Cosmetic surgery procedures are usually not considered eligible for coverage. This includes, but is not limited to, treatments, drugs, products, hospital/facility charges, anesthesia, pathology/lab fees, radiology fees and professional fees by the surgeon, assistant surgeon, consultants and attending physicians.
Congenital Anomaly	A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth
Functional or Physical Impairment	A functional or physical or physiological impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.
Reconstructive Procedures	Reconstructive Procedures when the primary purpose of the procedure is either of the following: ▪ Treatment of a medical condition ▪ Improvement or restoration of physiologic function Reconstructive Procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed

	or improved physical appearance. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior because of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

References

American Medical Association (AMA). CPT® Assistant Online. https://www.ama-assn.org/practicemanagement/cpt. Accessed August 19, 2024.

American Society of Plastic Surgeons (ASPS). https://www.plasticsurgery.org. Accessed August 19, 2024.

ConnectiCare Certificates of Coverage

Centers for Medicare & Medicaid Services. Women's Health and Cancer Rights Act (WHCRA). https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet. Accessed August 19, 2024.

U.S. Department of Labor. Women's Health and Cancer Rights Act (WHCRA). https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra. Accessed August 19, 2024.

Revision History

Company(ies)	DATE	REVISION
ConnectiCare	Mar. 26, 2025	Transferred policy content to individual company branded template Added Medical Policy page link to Table 2 header and removed policy-specific links within the table
EmblemHealth/ConnectiCare	Aug. 11, 2023	Updated cross-referencing links to Medical Policies
EmblemHealth/ConnectiCare	Aug. 12, 2022	Moved the following CPT codes to always cosmetic table: 11200, 11201, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15876, 15877, 15878, 15879 and 65771
EmblemHealth/ConnectiCare	Jun. 29, 2022	Removed CPT codes 17110 and 17111
EmblemHealth/ConnectiCare	May 31, 2022	Added CPT codes 21806 and 21807 to generally cosmetic table Removed medical record review requirement for CPT codes 10040, 15730, 15733, 40500