NO. 91535

COSMETIC AND RECONSTRUCTIVE SURGERY PROCEDURES

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Policy scope: This policy defines medically necessary determinations for cosmetic and reconstructive surgical procedures, including identification of not medically necessary cosmetic services and limited circumstances where reconstructive services may be medically necessary.

Related policies:

- Breast Related Procedures No. 91545
- Gender Affirming Surgery No. 91612
- Orthognathic Surgery No. 91273
- Panniculectomy/Abdominoplasty No. 91444
- Refractive Keratoplasty/Lasik No. 91529
- Septoplasty/Rhinoplasty No. 91506
- Skin Conditions No. 91456
- Surgical Treatments of Lipedema and Lymphedema No. 91631
- Surgical Treatment of Obesity No. 91595
- Varicose Vein Treatment No. 91326

I. POLICY/ CRITERIA

A. Cosmetic Surgery

1. Therapies and procedures intended to change or restore appearance for cosmetic purposes are considered not medically necessary. Cosmetic procedures ae not medically necessary regardless of the underlying causes of the condition, even when the procedure is expected to provide psychological benefit to the member.

2. In general, the following conditions and/or procedures are considered **not** medically necessary:
    a. Abdominoplasty (unless specified in Panniculectomy/Abdominoplasty medical policy # 91444)
    b. Birthmarks, blemishes
    c. Botox for wrinkles
    d. Breast augmentation/lift except when provided as part of post-mastectomy reconstructive services (See: Breast Related Procedures #91545)
    e. Brow lift
    f. Chemical peeling
    g. Collagen injections or implants
    h. Dermabrasion
    i. Diastasis recti repair
    j. Electrolysis
    k. Excision or repair of excess or sagging skin except panniculectomy
    l. Face lifts or related procedures to diminish the aging process
    m. Fat grafts, unless an integral part of another covered procedure
    n. Hair transplants or repair of any congenital or acquired hair loss, including hair analysis
    o. Labial Hypertrophy
    p. Laser facial resurfacing
    q. Laser hair removal
    r. Liposuction, unless an integral part of another covered procedure
    s. Moles/nevi (excluding atypical moles/dysplastic nevi)
    t. Orthodontic treatment, even when provided along with reconstructive surgery
    u. Otoplasty
    v. Refractive eye surgery (LASIK)
    w. Removal (any method) for excessive hair growth, even if caused by underlying medical condition
    x. Rhinophyma treatment
    y. Rhytidectomy (wrinkle removal)
    z. Salabrasion
    aa. Scalp cooling devices for prevention of chemotherapy-induced alopecia
    bb. Spider vein repair or removal
    cc. Tattoo removal
    dd. Torn ear lobe repair
    ee. Transgender procedures (unless identified as covered in the Gender Affirming Surgery medical policy 91612)

B. Therapeutic Reconstructive Surgery

1. Prior Plan approval is required from the Medical Director.

2. Therapeutic reconstructive surgery is medically necessary when it is performed to improve function as follows:
    a. Congenital anomaly that has resulted in a functional defect and repair was delayed for clinical reasons. Congenital anomaly is defined as a condition existing at or from birth that is a significant deviation from the common form or norm and is other than a common racial or ethnic feature.
    b. Treatment needed for the non-cosmetic repair of an accidental injury within a 24-month time frame of the injury. If repair is being performed in stages secondary to the extent of the injury, special consideration may be given to the extension of the 24-month requirement.
    c. As mandated by Federal or State laws such as in the case of breast reconstructive surgery following a mastectomy.

3. Revisions of prior surgery for aesthetic/cosmetic reasons are not covered unless there were surgical complications such as cellulitis, other infections, lymphedema, hematoma, or significant skin or flap necrosis.
    a. Examples of non-covered conditions include breast reconstruction, nipple fading, and loss of symmetry, for any reason, including tissue atrophy.

4. Submission of photographs **is required** for procedures with both reconstructive and cosmetic indications.

C. Clinical Functional Impairment

1. Prior Plan approval is required from the Medical Director.

2. Medical necessity is established when the documentation demonstrates significant clinical functional impairment. Clinical functional impairment exists when the defects and/or effects of illness or injury:
    a. Cause significant disability or major psychological trauma (Psychological reasons do not represent a medical or surgical necessity unless the member is undergoing psychotherapy for issues solely related to the illness or injury for which the reconstructive surgery is requested).
    b. Interfere with employment or regular attendance at school.
    c. Require surgery that is a component of a program of reconstruction surgery for congenital deformity or trauma, or
    d. Contribute to a major health problem.

3. Photographic documentation may be required as well.

D. Blepharoptosis and Brow Ptosis Repair

1. **Blepharoplasty** is considered medically necessary only when performed to address functional impairment (visual field obstruction). Blepharoplasty must be prior authorized and meet applicable InterQual criteria. Submission of photographic documentation **is required.**

   Potential indications for blepharoplasty include, but are not limited to, the following:
   a. Mechanical
      i. Blepharoconjunctivitis, or associated with true blepharoptosis
      ii. Dermatochalasis causing "pseudoptosis" with asthenopia
      iii. Disinsertion of the levator muscle
      iv. Ectropion or Entropion
      v. Epiblepharon

   b. Inflammatory
      i. Blepharochalasis with documented visual impairment
      ii. Floppy eyelid syndrome
      iii. Graves' ophthalmopathy and other metabolic disorders

   c. Traumatic
      i. Following skin grafting for eyelid tissue or eyelid reconstruction
      ii. Orbital fracture

2. Blepharoplasty performed for aesthetic or cosmetic purposes (i.e. surgery performed to reshape normal structures of the body to improve appearance) is considered not medically necessary.

3. **Brow Ptosis Repair** may be considered medically necessary when applicable InterQual criteria are met.

4. Submission of photographic documentation **is required.**

E. Scar Revisions and Removal

1. Facial Scar Revision:

   One facial scar revision may be considered medically necessary when all of the following criteria are met:
   a. The facial scar is the result of a traumatic injury/event or condition requiring surgical repair;
   b. The revision is performed within two years of the event that caused the injury, unless **one** of the following applies:
      i. The functional impairment was not recognized at the time of the injury, in which case, treatment must begin within two years of identification of impairment; **or**
      ii. Treatment must delayed due to developmental or growth-related considerations, in which case, revision may be performed when clinically appropriate.

Coverage is **limited to one (1) facial scar revision per affected area**. Member cost-sharing (copayments, coinsurance, and deductibles) applies in accordance with the applicable benefit plan.

2. Keloid Formation:
    a. Removal for formations due to body piercings and tattoos are considered cosmetic and not medically necessary.
    b. **Fractional ablative laser treatment (FLT)** for **keloid scars** is **not** medically necessary due to insufficient evidence of effectiveness.

3. **Post-Burn** Hypertrophic and Traumatic Scars:
    a. **Fractional ablative laser treatment (FLT)** with a CO_2 laser is considered medically necessary for post-burn hypertrophic and traumatic scars that **cause functional impairment.**

4. Submission of photographic documentation **is required.**

F. Port Wine Stains (PWS) and Vascular Malformations

Laser therapy for PWS or other vascular malformations is a covered benefit when determined to be medically necessary:

1. Laser therapy for PWS/vascular malformations is a covered benefit for ***any*** of the following:
    a. Subsection PWS on head or neck associated with other diseases or complications. Examples include PWS associated syndromes (e.g., Sturge-Weber, Wyburn-Mason, etc.), glaucoma, seizures, and spontaneous bleeding.
    b. PWS not on head or neck associated with central nervous system.
    c. Pediatric patients: Superficial PWS on head or neck for psychological or clinical prophylaxis.

2. Treatment for cosmetic reasons is not medically necessary.

G. Depending upon the situation, procedures may be considered cosmetic or reconstructive/medically indicated.

See the specific policies addressing these procedures:

- Abdominoplasty: See Panniculectomy/Abdominoplasty # 91444
- Bariatric Surgery: See Surgical Treatment of Obesity # 91595
- Breast Reconstruction: See Breast Related Procedures # 91545
- Breast Reduction: See Breast Related Procedures # 91545
- Breast Implant Explantation: See Breast Related Procedures # 91545
- Gender Affirming Surgeries: See Gender Affirming Surgery # 91612
- Orthognathic Surgery: See Orthognathic Surgery # 91273
- Panniculectomy: See Panniculectomy/Abdominoplasty # 91444
- Reduction Mammoplasty: See Breast Related Procedures # 91545
- Refractive Keratoplasty: See Refractive Keratoplasty/Lasik # 91529
- Rhinoplasty: See Septoplasty/Rhinoplasty # 91506

- Selected Skin Conditions: See Skin Conditions # 91456
- Varicose Vein Treatments: See Varicose Vein Treatment # 91326

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
NCD 110.6 - Scalp Hypothermia During Chemotherapy to Prevent Hair Loss	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	None Identified
First Coast Service Options, Inc.	None Identified
National Government Services, Inc.	None Identified
Noridian Healthcare Solutions	None Identified
Novitas Solutions, Inc.	None Identified
Palmetto GBA	L39573 - Scalp Cooling for the Prevention of Chemotherapy-Induced Alopecia
WPS Insurance Corporation	L34528 - Blepharoplasty, Blepharoptosis and Brow Lift

III. BACKGROUND

Cosmetic Reconstruction and Surgery Procedures
Plastic surgery is a general term for operative manual and instrumental treatment, which is performed, for functional or cosmetic reasons. The word "plastic" derives from the Greek “plastikos” meaning to “mould or to shape”.

The principal areas of plastic surgery include two broad fields. Cosmetic surgery is performed on normal structures of the body primarily to improve appearance and/or self-esteem rather than to restore the anatomy and/or functions of the body that are lost or impaired due to an illness or injury. Cosmetic surgery is not considered a medical necessity.

Reconstructive surgery, including microsurgery, focuses on undoing or masking the destructive effects of trauma, surgery or disease. It is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection,

tumors, or disease. Reconstructive surgery is often performed on burn and accident victims. It may involve the rebuilding of severely fractured bones, as well as skin grafting. Reconstructive surgery includes such procedures as the reattachment of an amputated finger or toe or implanting a prosthesis. It is generally performed to improve function but may also be done to approximate a normal appearance.

Blepharoptosis/Brow Ptosis Repair
Blepharoplasty is performed for either functional or cosmetic purposes. The goal of functional reconstructive surgery is to restore normal structure that has been altered by trauma, infection, inflammation, degeneration, neoplasia or developmental errors. The most common functional indication for blepharoplasty is a superior visual field defect secondary to redundant upper eyelid tissue (dermatochalasis) that overhangs the eyelid margin. The best candidates for eyelid surgery are men and women who are physically healthy, psychologically stable and realistic in their expectations. Most are 35 or older, but if droopy, baggy eyelids run in the family, surgery may be indicated at a younger age.

Symptoms related to ptosis or dermatochalasis include decreased visual fields (most commonly superior), symptoms of fatigue from keeping the eyes open, brow ache, or sensation of the upper lid skin resting on the lashes.

Scar Removal or Revision
Facial Scar Revisions
Facial scars resulting from traumatic injury may remain conspicuous despite appropriate primary repair and can have a disproportionate impact on appearance, psychosocial well-being, and social functioning (American Society of Plastic Surgeons [ASPS], 2024). The face is uniquely visible, and traumatic facial injuries are frequently repaired emergently or under suboptimal conditions, which may limit the ability to optimize scar placement, orientation along relaxed skin tension lines, or cosmetic outcomes at the time of initial treatment (Garg et al., 2014).

Professional societies, including the American Society of Plastic Surgeons (ASPS) and the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), characterize facial scar revision as a reconstructive intervention when performed to improve the appearance of scars resulting from trauma, burns, or medically necessary surgery, rather than as purely cosmetic treatment (ASPS, 2024; AAFPRS, 2023). Society guidance emphasizes that scar revision does not eliminate a scar but may improve scar visibility, contour, texture, or distortion of adjacent anatomic structures through techniques such as excision and re-orientation of the scar, local tissue rearrangement (e.g., Z-plasty or W-plasty), or adjunctive resurfacing procedures (Garg et al., 2014).

Timing considerations are central to facial scar management. Scar maturation typically evolves over 12 months or longer, and revision is commonly deferred until the scar has stabilized unless delayed recognition of functional or cosmetic impairment, growth-related considerations, or anatomic distortion justify later intervention (Garg et al., 2014; ASPS, 2024). Society guidance consistently emphasizes individualized clinical assessment, realistic patient expectations, and restraint in the use of repeated or iterative revisions.

Overall, contemporary clinical guidance supports a limited and selective approach to facial scar revision following **traumatic injury**, recognizing that a single revision may be appropriate to address significant residual deformity when initial repair conditions precluded optimal cosmetic outcome. Repeated revisions or procedures performed solely

to pursue incremental cosmetic improvement are not supported in society guidance and are generally considered outside the scope of reconstructive care (ASPS, 2024; AAFPRS, 2023).

Fractional laser treatment with a CO_2 laser

Hypertrophic scarring is a common complication following **burn injury**, with reported incidence rates of up to 70% in burn survivors. Burn-related hypertrophic scars may result in substantial morbidity, including pain, pruritus, dyschromia, scar stiffness, and restricted range of motion due to scar thickening and contracture formation (Fu et al., 2019; Anderson et al., 2014). These functional limitations can interfere with rehabilitation, joint mobility, and quality of life, particularly when scars cross joints or involve areas of high tension (Anderson et al., 2014). Management of hypertrophic burn scars is typically multimodal and may include pressure therapy, silicone-based products, physical and occupational therapy, intralesional corticosteroids, and surgical intervention in severe or fixed contractures (Klifto et al., 2020).

Fractional ablative carbon dioxide (CO_2) laser therapy has emerged as an adjunctive, nonsurgical modality for the management of **hypertrophic and traumatic burn scars.** Fractional CO_2 lasers create microscopic columns of controlled thermal injury (microthermal treatment zones) within scar tissue while preserving surrounding epidermis and dermis, promoting rapid re-epithelialization and initiating a wound-healing response that supports collagen remodeling and improved tissue pliability (Anderson et al., 2014; Klifto et al., 2020). Histopathologic studies of mature hypertrophic burn scars treated with fractional CO_2 laser demonstrate reorganization of dermal collagen architecture, including a shift toward a collagen profile more closely resembling uninjured skin (Ozog et al., 2013).

The clinical evidence supporting fractional CO_2 laser therapy for hypertrophic burn scars has expanded beyond early observational studies. Systematic reviews and meta-analyses evaluating burn-related hypertrophic scars report statistically significant improvements in validated scar assessment measures, including the Vancouver Scar Scale (VSS) and Patient and Observer Scar Assessment Scale (POSAS), particularly in scar pliability, thickness, vascularity, and pigmentation (Mahar et al., 2021; Ma et al., 2023). In the ELIPSE prospective randomized controlled trial, early intervention with ablative fractional CO_2 laser in burn scars resulted in improvements in patient-reported scar thickness and texture, favorable blinded photographic assessments, and biologic changes in fibroblast gene expression consistent with scar remodeling (Lewis et al., 2023). Although heterogeneity remains in laser platforms, treatment parameters, and intervals, the overall body of evidence supports a beneficial role for fractional CO_2 laser therapy as part of comprehensive burn scar rehabilitation.

Guideline and consensus statements reflect this evolving evidence base. The International Society for Burn Injury (ISBI) Practice Guidelines for Burn Care (2016) acknowledge laser therapy as a potential modality within the nonsurgical management of hypertrophic burn scars, while emphasizing that the quality of evidence at the time of publication was limited and that laser treatments should be considered adjunctive to established scar management strategies and rehabilitation programs (ISBI, 2016). More recent international consensus recommendations on traumatic scars and contractures identify ablative fractional lasers as commonly utilized for thick, function-limiting traumatic and burn scars, particularly to improve scar pliability and symptoms, while noting that

laser therapy does not replace surgical release for severe, fixed contractures (Seago et al., 2020).

Fractional CO_2 laser therapy is generally well tolerated in burn populations when performed by experienced clinicians using conservative, scar-appropriate settings. Reported adverse effects are typically mild and transient and may include temporary pain, erythema, edema, blistering, or epidermal sloughing, with low overall complication rates in published series (Won et al., 2023). As such, fractional CO_2 laser therapy is best viewed as an adjunctive intervention within a multidisciplinary burn scar management framework rather than a stand-alone or definitive treatment.

Importantly, this background and evidence base apply **only to hypertrophic and traumatic burn scars**. **Keloids represent a distinct pathologic entity** with different biology, clinical behavior, and treatment response. The Keloid Research Foundation (KRF) Clinical Treatment Strategy Guidelines describe keloid disorder as a genetically mediated dysregulation of wound healing and specifically advise against the use of laser monotherapy for keloids due to high recurrence rates and limited durable benefit (Tirgan, 2019). Accordingly, evidence supporting fractional CO_2 laser therapy for hypertrophic *burn* scars should not be extrapolated to keloid scars, which are outside the scope of this indication.

Port Wine Stains and Vascular Malformations
Port wine stains (PWS) are congenital anomalies that may occur anywhere on the body.

PWS Classifications:

I. Grade I lesions: vessel diameters are in the 80 μm range. These lesions are light pink macules.
II. Grade II lesions: vessel diameters measure up to 120 μm. These lesions are darker pink macules.
III. Grade III lesions: vessel diameters measure up to 150 μm. These lesions are red macules.
IV. Grade IV lesions: vessel diameters are greater than 150 μm. These lesions are purple and may become papular.

Vascular malformations are abnormal clusters of blood vessels that occur during fetal development. Although they are always present at birth, they may not be visible until weeks or even years after birth. These lesions will typically grow in proportion to the growth of the child. While they sometimes grow quite rapidly, their growth is usually gradual and steady during the first year of life. Without treatment, a vascular malformation will not diminish or disappear. Port wine stains are vascular malformations that are present at birth and occur primarily on the face and neck. PWS grow proportionately with the child, darken with age, and do not fade or disappear. Long-term complications are psychological disturbances and skin hypertrophy which increases the risk of spontaneous bleeding.

The treatment of choice is pulsed dye laser therapy for light skin. However, the Nd: YAG infrared laser is the laser of choice for dark skin. Due to the deficiency or absence of nerve supply to the blood vessels, the blood will in time repool and the PWS will once again reappear. Maintenance laser treatments are necessary since it is common for PWS to recur after several years.

The psychological impact of Port Wine Stains is not well established. In a survey study conducted by Hansen et al, patients were asked to quantify changes in their PWS as well as their psychological well-being. The vast majority of patients noted little or no change in texture, height, or dimension of their PWS, whereas 62% noted color improvement. A majority of patients (60%) worried less about their appearance after treatment, whereas a similar number (61%) believed their ability to make friends or meet others was unaffected by treatment. Only 19% thought others looked at or treated them differently because of their PWS. Overall, 48% of patients indicated satisfaction with treatment, 24% dissatisfaction, and 28% neutral. The authors concluded that pulsed-dye laser improves the color of PWS over long periods of time in most patients. Patients tended to worry less about their appearance after treatment, although most believed treatment did not substantially affect their relationship with others or others' view of them. Most patients were satisfied or neutral with regard to satisfaction with therapy and would recommend treatment to others. A minority of patients was dissatisfied with treatment, and men were more likely to be dissatisfied. Additional long-term and prospective studies will be helpful in assessing the physical and psychosocial impact of PDL for PWS.

In another study by Kurwa et al, over a 5-year period all 249 patients (192 females and 57 males) aged 15 years and older with a port wine stain (PWS) attending a laser clinic completed a psychological questionnaire at their first visit. The overall mean score (OMS) expressed as a percentage of the maximum possible score of 32 (%OMS) for all patients was 61.7%. Researchers found that the mean score was significantly higher for females (%OMS 63.8%; OMS 20.42, SD 7.9) than for males (%0MS 54.7%; OMS 17.5, SD 7.4; $P<0.05$). Patients with facial PWS (n = 208) had a %OMS of 59.4% (OMS 19.0, SD 7.8) whereas those with PWS on the body (n=41) had a %OMS of 72.2% (OMS 23.1, SD 7.1; $P<0.05$). There was no significant difference found in the OMS between different age groups, between flat or raised PWS or between different colored PWS. Of the 249 patients entered, 53 (21.3%) completed laser therapy and returned completed post-treatment questionnaires. For this cohort the %OMS prior to treatment was 61.2% (OMS 19.6, SD 8.17) and fell to 35.2% (11.3, SD 10.05) after completing therapy ($P<0.001$). The greatest improvement was seen in response to questions on feelings of anxiety and embarrassment and the need to hide the PWS.

A 2017 study by Hagen et al surveyed 244 adults with facial PWS. The survey consisted of a quality of life (QoL) questionnaire, which included the Skindex-29 instrument. Results of the survey indicated that QoL in adults with facial PWS was diminished, especially from an emotional perspective. Variables associated with reduced QoL in all Skindex-29 subdomains included comorbid depression, limited facial mobility, and presence of other skin conditions. People with hypertrophy had more emotional and symptomatic impairment. The composite dermatologic-specific QoL scores were similar to those of cutaneous T-cell lymphoma, rosacea, alopecia, and vitiligo. The authors acknowledged that selection bias was a potential limitation, as participants were primarily recruited from patient support groups.

The optimal timing for PWS is controversial, although many experts agree that early treatments can provide improved results. A consensus statement published in JAMA Dermatology in 2020 states the following: “Based on expert observations and limited studies, treatment of PWBs at an earlier age, particularly in the first year of life, results in better outcome.” (Sabeti S, et al 2020).

Scalp Cooling Devices for Prevention of Chemotherapy-Induced Alopecia

Scalp cooling devices, also referred to as cooling caps or cold caps, are devices designed to lower the temperature of the scalp before, during, and after chemotherapy infusion (i.e., scalp hypothermia) with the goal of reducing chemotherapy-induced alopecia CIA. While these devices vary in design, all aim to lower scalp temperature to constrict blood vessels and lower metabolic activity in hair follicles, thereby limiting the amount of cytotoxic drug that reaches the follicular cells. This cooling effect helps protect follicles from chemotherapy-induced damage and can reduce the risk or severity of CIA.

Devices range from precooled manual cooling caps, such as the Penguin Cold Cap (Penguin Cold Caps) or Arctic Cold Cap (Arctic Cold Caps LLC), to continuous cooling systems that are self-contained with integrated temperature sensors and/or coolant-circulating pumps for automated temperature regulation. Examples of automated systems include the DigniCap Scalp Cooling System (Dignitana AB), Paxman Scalp Cooling System (Paxman Coolers Ltd), and Amma Scalp Cooling System (Cooler Heads Care Inc.). While scalp cooling is not appropriate for all patients or chemotherapy regimens, automated scalp cooling systems are currently the only U.S. Food and Drug Administration (FDA)-cleared intervention for the prevention of CIA in patients receiving chemotherapy for solid tumor cancers. Notably, manual scalp cooling devices are not regulated by the FDA.

An open-label randomized controlled trial compared scalp cooling versus control in newly diagnosed patients with breast cancer stages I-III who were scheduled to receive neoadjuvant or adjuvant chemotherapy with curative intent between December 2020 and August 2021. Patients were randomly assigned (2:1 ratio) to scalp cooling or usual clinical practice. The primary outcome was persistent chemotherapy-induced alopecia (PCIA) 6 months after chemotherapy. Hair thickness and density were measured using Folliscope 5.0. CIA-related distress was assessed using the CIA distress scale (CADS), with a higher score reflecting higher stress. The proportion of patients with PCIA at 6 months was 13.5% (12/89) in the scalp-cooling group and 52.0% (26/50) in the control group. The average difference in the change in hair thickness from baseline between the scalp-cooling and control groups was 9.0 μm in favor of the intervention group. The average difference in the change in hair density between intervention and control at the end of the study was -3.3 hairs/cm2. At 6 months after chemotherapy, the average difference in the change in CADS score between the intervention and control groups was -3.2 points, reflecting reduced CIA-related stress in the intervention group. The authors concluded that more studies are needed to determine long-term benefits of scalp cooling (Kang et al., 2024)

In a systematic review and meta-analysis published in 2024, 31 studies were included analyzing scalp hypothermia as a possible method to prevent severe CIA. The outcome studied was the proportion of patients with <50% hair loss. Among 2179 included patients, 60.7% were reported to have <50% hair loss (meta-analysis: 60.6%, 95% confidence interval [CI] 54.9-66.1%). Among the 28 studies reporting only on taxane-based chemotherapy, the rate of <50% hair loss was 60.0% (meta-analysis: 60.9%, (95% CI: 54.9-66.7%). In comparative studies, hair loss was significantly less in patients who received scalp hypothermia versus those who did not (49.3% versus 0% with <50% hair loss; OR 40.3, 95% CI: 10.5-154.8). Scalp cooling achieved <50% hair loss in patients receiving paclitaxel (67.7%; meta-analysis 69.9%, 95% CI 64.1-75.4%) and docetaxel (57.1%; meta-analysis 60.5%, 95% CI 50.0-71.6%). Meta-analysis on patient satisfaction in regard to scalp cooling found a satisfaction rate of 78.9% (95% CI 69.1-87.4%). (Lambert et al., 2024)

Scalp cooling does not add to cancer treatment or medical care. Priority Health considers cooling caps and other products for scalp cooling incidental to the chemotherapy administration and are not separately reimbursed.

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
European Society for Medical Oncology (ESMO)	Prevention and Management of Dermatological Toxicities Related to Anticancer Agents: ESMO Clinical Practice Guidelines (2021)
Cancer Australia	Guidance for the Management of Early Breast Cancer: Recommendations and Practice Points (2020)
National Comprehensive Cancer Network (NCCN)	NCCN Guidelines 2026 Invasive Breast Cancer

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

Device	Premarket Approval, 513(f)(2)(De Novo), or 510(k) Number	Notice date

VI. CODING

Cosmetic Reconstruction and Surgery Procedures
ICD-10 Codes that EXCLUDE coverage of any services:

Z41.1 Encounter for cosmetic surgery
Z41.8 Encounter for other procedures for purposes other than remedying health state
Z41.9 Encounter for procedure for purposes other than remedying health state, unspecified
Z42.8 Encounter for other plastic and reconstructive surgery following medical procedure or healed injury

CPT/HCPCS Codes

*The following codes are generally **not** medically necessary. *Auth required for exception to exclusion. List should not be considered inclusive of all possible applicable codes. Refer to specific medical policies for exception criteria, if applicable.*

10040 Extraction (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)

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 (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
11960*	Insertion of tissue expander(s) for other than breast, including subsequent expansion
15769*	Grafting of autologous soft tissue, other, harvested by direct excision (e.g, fat, dermis, fascia)
15771*	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772*	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
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
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)
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site, (e.g., tattoo removal)
15786	Abrasion; single lesion (e.g., keratosis, scar)
15787	Abrasion; each additional four lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal

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 (*covered for indications in policy 91631 only)*
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg (*covered for indications in policy 91631 only)*
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip (*covered for indications in policy 91631 only)*
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock (*covered for indications in policy 91631 only)*
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm (*covered for indications in policy 91631 only)*
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand (*covered for indications in policy 91631 only)*
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); 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	Suction assisted lipectomy; upper extremity *(covered for indications in policy 91631 only)*
15879	Suction assisted lipectomy; lower extremity *(covered for indications in policy 91631 only)*
17340	Cryotherapy (CO2 slush, liquid N2) for acne
17360	Chemical exfoliation for acne (e.g., acne paste, acid)
17380	Electrolysis epilation, each 30 minutes
19316	Mastopexy
19355	Correction of Inverted Nipples
21120*	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21137*	Reduction forehead; contouring only
21138*	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139*	Reduction forehead; contouring and setback of anterior frontal sinus wall
21125*	Augmentation, mandibular body or angle; prosthetic material
21127*	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)

21150*	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)
21151*	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)
21154*	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I
21155*	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I
21159*	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160*	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort
21172*	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175*	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179*	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180*	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21181*	Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial
21182*	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq. cm
21183*	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq. cm but less than 80 sq. cm
21184*	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater th21an 80 sq. cm
21230*	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235*	Graft; ear cartilage, autogenous, to nose or ear (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
21247*	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia)
21255*	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)

21256*	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (e.g., micro-ophthalmia)
21260*	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261*	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach
21263*	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement
21267*	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268*	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach
21270*	Malar augmentation, prosthetic material
21275*	Secondary revision of orbitocraniofacial reconstruction
21280*	Medial canthopexy (separate procedure)
21282*	Lateral canthopexy
21295*	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach
21296*	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach
26590*	Repair macrodactylia, each digit
30120	Excision or surgical planing of skin of nose for rhinophyma
56620	Vulvectomy simple; partial ○ for dx N90.6 Hypertrophy of vulva *(labial hypertrophy*)
69090	Piercing of Ear
69300	Otoplasty, protruding ear, with or without size reduction
69310*	Reconstruction of external auditory canal (meatoplasty) (e.g., for stenosis due to injury, infection) (separate procedure)
69320*	Reconstruction external auditory canal for congenital atresia, single stage

Blepharoptosis and Brow Ptosis Repair

ICD-10 Codes that <u>may</u> apply:

C43.10 – C43.12	Malignant melanoma of eyelid, including canthus
C44.101 – C44.199	Malignant neoplasm of skin of eyelid, including canthus
D03.10 – D03.12	Melanoma in situ of eyelid, including canthus
D04.10 – D04.12	Carcinoma in situ of skin of eyelid, including canthus
D04.30 – S04.39	Carcinoma in situ of skin of other part of face
D22.10 – D22.12	Melanocytic nevi of eyelid, including canthus
D23.10 – D23.12	Other benign neoplasm of skin of eyelid, including canthus
E05.00	Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm
G24.5	Blepharospasm
G51.9	Disorder of facial nerve, unspecified
H02.001 – H02.059	Entropion and trichiasis of
H02.101 – H02.139	Unspecified ectropion of eyelid
H02.211 – H02.239	Cicatricial lagophthalmos
H02.30 – H02.36	Blepharochalasis

H02.401 – H02.439	Ptosis of eyelid
H02.521 – H02.529	Blepharophimosis
H02.531 – H02.539	Eyelid retraction
H02.831 – H02.839	Dermatochalasis of eyelid
H02.89	Other specified disorders of eyelid
H05.20	Unspecified exophthalmos
H10.501 – H10.509	Unspecified blepharoconjunctivitis
Q10.0 – Q10.3	Congenital malformations of eyelid
S00.10xA – S00.12xS	Contusion of eyelid and periocular area
S01.101A – S01.109S	Unspecified open wound of eyelid and periocular area
S01.111A – S01.119S	Laceration without foreign body of eyelid and periocular area
S01.121A – S01.129S	Laceration with foreign body of eyelid and periocular area
S01.131A – S01.139S	Puncture wound without foreign body of eyelid and periocular area
S01.141A – S01.149S	Puncture wound with foreign body of eyelid and periocular area
S01.151A – S01.1159S	Open bite of eyelid and periocular
T26.00xA – T26.02xS	Burn of eyelid and periocular area
T26.50xA – T26.52xS	Corrosion of eyelid and periocular area

CPT/HCPCS Codes

15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material
67902	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type)
67909	Reduction of overcorrection of ptosis

Facial Scar Revisions

ICD-10 Codes that apply:

L90.5	Scar conditions and fibrosis of skin
L91.0	Hypertrophic scar

CPT/HCPCS Codes

All procedures billed with the diagnoses above, fall under the scope of this policy:

Medication

Physician Services including injections

Surgery – including but not limited to:

11300 – 11313 Shaving
11400 – 11446 Excision
11900 – 11901 Injection
11950 – 11954 Filling
12001 – 14350 Repair
15781 – 15787 Abrasion
17000 –17004, 17110- 17111, 17250 Destruction

Services may be subject to benefit limitations (*refer to plan documents for benefit details)*

Fractional Ablative Laser Treatment
ICD-10 Codes:
L90.5 Scar conditions and fibrosis of skin
L91.0 Hypertrophic scar

CPT/HCPCS Codes
0479T Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants and children
0480T Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)

Port Wine Stains and Vascular Malformations
ICD-10 Codes that apply:
D18.00 – D18.09 Hemangioma
Q82.5 Congenital non-neoplastic nevus

CPT/HCPCS Codes:
General services that may be subject to benefit limitations *(refer to plan documents for benefit details)*
Medication
Imaging
Lab/Path
Physician Services including injections
Surgery – including but not limited to:
11300 – 11313 Shaving

11400 – 11446 Excision

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

Scalp Cooling Devices for Prevention of Chemotherapy-Induced Alopecia
CPT/HCPCS Codes

Not separately payable

97007	Mechanical scalp cooling, including individual cap supply with head measurement, fitting, and patient education
97008	Mechanical scalp cooling; including hair preparation, individual cap placement, therapy initiation, and precooling period
97009	Mechanical scalp cooling; provided after discontinuation of chemotherapy, each 30 minutes (List separately in addition to code for primary procedure)

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

To access InterQual guidelines: Log into Priority Health Prism → Authorizations → Authorization Criteria Lookup.

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health

contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

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SUMMARY OF CHANGES

Additions:

- Added ICD-10 L91.0 (Hypertrophic scar) as a medically necessary diagnosis for fractional ablative laser treatment to coding section.

Changes:

- Updated language to clarify Section "E": Scar Revisions and Removal, specifically facial scar revision and post-burn hypertrophic and traumatic scars. Prior Authorization will be required.
- Moved the statement regarding fractional ablative laser treatment for keloid scars from the Hypertrophic and traumatic scars section (E.3) to the keloid section (E.2).
- Updated language in medical policy to remove the term "covered", aligning with standardized medical necessity phrasing.
- Updated coding and diagnosis sections to reflect changes.
- Converted policy to new standardized template.
- Updated background section and references.

Past committee review dates: 07/2007, 06/2008, 06/2009, 10/2009, 10/2010, 02/2011, 02/2012, 02/2013, 02/2014, 02/2015, 02/2016, 02/2017, 02/2018, 02/2019, 11/ 2019, 02/2020, 02/2021, 05/2021, 05/2022, 05/2023, 05/2024, 05/2025, 11/2025, 05/2026

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