Priority Health	BILLING POLICY No. 197
COSMETIC AND RECONSTRUCTUVE SURGERY	
Date of origin: May 28, 2026	**Review dates: 8/2026**

POLICY DESCRIPTION

This policy outlines billing and payment requirements associated with Cosmetic & Reconstructive Surgery. This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual and industry standards.

DEFINITION

Cosmetic and reconstructive surgery procedures include services performed to improve appearance (cosmetic) or restore function or correct abnormalities caused by birth conditions, injury, or disease (reconstructive). Cosmetic procedures enhance appearance without affecting function, while reconstructive procedures restore or improve function or correct deformities.

MEDICAL POLICY

- Cosmetic and Reconstructive Surgery Procedures #91535

FOR MEDICARE

For indications that don't meet the criteria of NCD, local LCD, or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Cosmetic procedures are not reimbursable when done only to improve appearance. Reconstructive procedures may be reimbursed when medically necessary to restore function or correct abnormalities. Services must be properly documented, may require prior authorization, and must be billed with appropriate diagnosis codes. Procedures without functional impairment or cosmetic revision are not payable.

Coding specifics

Cosmetic Reconstruction and Surgery Procedures
ICD-10 Codes that Exclude coverage for any service

Codes	Description
Z41.1	Encounter for cosmetic surgery
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

Claims will be denied when:

- Diagnosis indicates a cosmetic purpose (e.g., Z41.1)
- Documentation does not support reconstructive intent or functional impairment
- Diagnosis coding does not support medical necessity

- Required diagnosis information (including supporting diagnoses when applicable) is not reported

CPT/HCPCS Codes

The following CPT/HCPCS codes are grouped per CMS Article Cosmetic and Reconstructive Surgery A58774 and are subject to medical necessity, diagnosis coding, and benefit limitations. Please consult the Medical Policy #91535 for specific details.

RECONSTRUCTIVE BREAST SURGERY: REMOVAL OF BREAST

Code	Description
19316	Mastopexy
19325	Breast augmentation with implant
19328	Removal of intact breast implant
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)
19340	Insertion of breast implant on same day of mastectomy (i.e., immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19361	Breast reconstruction; with latissimus dorsi flap
19364	Breast reconstruction; with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap
19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)
19369	Breast reconstruction, with bipedicle transverse rectus abdominismyocutaneous (TRAM) flap
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents
19380	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction
19396	Preparation of moulage for custom breast implant

REDUCTION MAMMAPLASTY

Code	Description
19318	Breast reduction

MASTECTOMY FOR GYNECOMASTIA

Code	Description
19300	Mastectomy for gynecomastia

TATOOING

Code	Description
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

PUNCH GRAFT

Code	Description
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts

RHINOPLASTY/NASAL RECONSTRUCTIVE SURGERY

Code	Description
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

DERMABRASION

Code	Description
15781	Dermabrasion; segmental, face

CHEMICAL PEEL

Code	Description
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal

ABDOMINAL LIPECTOMY/PANNICULECTOMY

Code	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical 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)
15877	Suction assisted lipectomy; trunk

DERMAL FILLER AND INJECTION

Code	Description
G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)
Q2026	Injection, Radiesse, 0.1 ml
Q2028	Injection, sculptra, 0.5 mg

The following CPT codes and procedures are generally considered cosmetic and may be reviewed or denied as non-covered services.

Code	Description
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (eg, tattoo removal)
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
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17340	Cryotherapy (CO2 slush, liquid N2) for acne
17360	Chemical exfoliation for acne (eg, acne paste, acid)
17380	Electrolysis epilation, each 30 minutes
69300	Otoplasty, protruding ear, with or without size reduction

Claims must include diagnosis coding that supports medical necessity in accordance with CMS LCA requirements. All applicable diagnoses should be reported. Claims with insufficient diagnosis information may be denied.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Reconstructive Breast Surgery: Removal of Breast Implants

The medical record must document the condition supporting the medical necessity for implant removal.

Breast Reduction

The medical record must include the following information:

- Height and weight
- Body surface area (BSA)
- Documentation of clinical evaluation of signs and/or symptoms attributed to macromastia, including prior therapies and the patient's response to those therapies
- The operative report, including the weight of tissue removed from each breast as measured in the operating room
- The pathology report documenting the weight of tissue removed from each breast

- Documentation of back, neck, or shoulder pain related to macromastia that persists despite at least six months of conservative treatment, including analgesics, supportive measures (e.g., garments), and physical therapy

Mastectomy for gynecomastia

- Glandular breast tissue consistent with true gynecomastia is documented on physical examination and/or confirmed by mammography.
- Documentation confirming that gynecomastia continues despite treatment or resolution of any underlying causes.
- Documentation demonstrating that the gynecomastia meets Grade III or IV criteria according to the American Society of Plastic Surgeons classification.
- Documentation confirming that hormonal causes such as hyperthyroidism, excess estrogen, high prolactin, and low testosterone have been ruled out through appropriate lab testing (e.g., TSH, estradiol, prolactin, testosterone, or LH levels).
- Documentation showing that gynecomastia continues after at least 6 months of unsuccessful medical treatment, that use of drugs or substances known to cause gynecomastia has been ruled out, and that the condition has been present for at least one year (per ASPS).

Tattooing

Progress notes must document the prior condition (e.g., post-mastectomy or trauma) that require reconstruction to correct the skin color defect.

Punch graft hair transplants

Pre-operative photographs must be provided if requested by the Contractor.

Rhinoplasty

- The medical record must include details describing the condition that necessitates rhinoplasty.
- If performed for chronic obstruction, the medical record must identify the underlying cause of the obstruction.
- Documentation of anterior rhinoscopy, endoscopy, Cottle or modified Cottle maneuver, and/or CT findings is recommended to support medical necessity, if requested.
- The medical record should describe any conservative treatments used to address the obstruction and specify the duration of those treatments.
- Post-operative surgical and/or pathology report, if applicable.

Septoplasty

- The medical record must document the medical and antibiotic treatments used, as well as the duration of therapy, for recurrent sinusitis caused by a deviated septum.
- When the procedure is performed to correct an asymptomatic septal deformity solely to facilitate access to other trans nasal structures during a separate medically necessary surgery, the medical record must clearly identify the primary surgical procedure being performed.

- The medical record must document the medical management provided and the duration of treatment trialed for obstructed nasal breathing caused by septal deformity or deviation that interferes with the effective use of Continuous Positive Airway Pressure (CPAP) therapy for an obstructive sleep disorder.

Dermabrasion
The medical record must clearly document the injury, surgical procedure, or disease process that led to the defect.

Abdominal Lipectomy/ Panniculectomy
The medical record must include:

- the evaluation and management documentation supporting medical necessity and/or complications that led to the decision to proceed with surgery,
- operative report documentation
- description of the pannus and the condition of the underlying skin,
- documentation indicating that the panniculus results in chronic intertrigo (inflammation of opposing skin surfaces, including irritation, infection, or chafing),
- summary of conservative treatments attempted and the outcomes achieved,
- evidence demonstrating that the individual has maintained a stable weight for a minimum of six months.

Rhytidectomy

- Documentation should include the evaluation and management note where the decision for surgery was made, the surgical note, and any records showing functional impairment.

Resources

- CMS Billing and Coding: Cosmetic and Reconstructive Surgery

Related policies

Related denial language

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require

industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
May 28, 2026	New policy
August 2026	Policy Overview is a new section. The CPT list of codes that may be reviewed for approval has been added. Also, verbiage claims that must include diagnosis coding that supports medical necessity in accordance with CMS LCA requirements has been added.