

Cosmetic and Reconstructive Procedures (for New Mexico Only)

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[Instructions for Use](#)

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Related Policies

- [Breast Reconstruction \(for New Mexico Only\)](#)
- [Breast Reduction Surgery \(for New Mexico Only\)](#)
- [Brow Ptosis and Eyelid Repair \(for New Mexico Only\)](#)
- [Gender Dysphoria Treatment \(for New Mexico Only\)](#)
- [Liposuction for Lipedema \(for New Mexico Only\)](#)
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- [Orthognathic \(Jaw\) Surgery \(for New Mexico Only\)](#)
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- [Pectus Deformity Repair \(for New Mexico Only\)](#)
- [Plagiocephaly and Craniosynostosis Treatment \(for New Mexico Only\)](#)
- [Rhinoplasty and Other Nasal Procedures \(for New Mexico Only\)](#)
- [Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins \(for New Mexico Only\)](#)

Application

This Medical Policy only applies to the state of New Mexico.

Coverage Rationale

[See Benefit Considerations](#)

Reconstructive Procedures

A procedure is considered 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 individual's physiological function

Note: [Microtia](#) repair is considered Reconstructive although no Functional Impairment may be documented.

Tissue Transfer (Flap) Repair

Flap repair is considered **Reconstructive and medically necessary in certain circumstances**. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Tissue Transfer (Flap).

[Click here to view the InterQual® criteria.](#)

Cosmetic Procedures

Cosmetic Procedures are generally not covered. Cosmetic Procedures are procedures or services that change or improve appearance without significantly improving physiological function. A procedure is considered to be a Cosmetic Procedure when it does not meet the Reconstructive criteria in the *Reconstructive Procedures* section above.

Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are generally considered Cosmetic Procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result 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](#).

Definitions

The following definitions may not apply to all plans. Refer to the federal, state, and contractual requirements for applicable definitions.

Cosmetic Surgery: Cosmetic Surgery is performed to reshape normal structures of the body in order to enhance an individual's appearance and self-esteem (Freeman, 2023).

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 (Medicare, 2023).

Microtia: Microtia is a birth defect of a baby's ear. Microtia happens when the external ear is small and not formed properly. The defect can vary from being barely noticeable to being a major problem with how the ear forms. Usually, Microtia affects how the baby's ear looks, but the parts of the ear inside the head are not affected [Centers for Disease Control and Prevention (CDC), 2023].

Reconstructive Surgery: 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 [Certificate of Coverage (COC), 2018].

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| CPT/HCPCS Code | Description |
|---|---|
| The following codes may be Cosmetic; review is required to determine if considered Cosmetic or Reconstructive. | |
| 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) |

| CPT/HCPCS Code | Description |
|---|--|
| The following codes may be Cosmetic; review is required to determine if considered Cosmetic or Reconstructive. | |
| 11960 | Insertion of tissue expander(s) for other than breast, including subsequent expansion |
| 14000 | Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less |
| 14001 | Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm |
| 14020 | Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less |
| 14021 | Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm |
| 14040 | Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less |
| 14041 | Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm |
| 14060 | Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less |
| 14061 | Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm |
| 14301 | Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm |
| 14302 | Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure) |
| 15570 | Formation of direct or tubed pedicle, with or without transfer; trunk |
| 15572 | Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs |
| 15574 | Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet |
| 15730 | Midface flap (i.e., zygomaticofacial flap) with preservation of vascular pedicle(s) |
| 15731 | Forehead flap with preservation of vascular pedicle (e.g., axial pattern flap, paramedian forehead flap) |
| 15733 | Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (i.e., buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae) |
| 15734 | Muscle, myocutaneous, or fasciocutaneous flap; trunk |
| 15736 | Muscle, myocutaneous, or fasciocutaneous flap; upper extremity |
| 15738 | Muscle, myocutaneous, or fasciocutaneous flap; lower extremity |
| 15740 | Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel |
| 15756 | Free muscle or myocutaneous flap with microvascular anastomosis |
| 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 Note: Refer to the Medical Policy titled Breast Reconstruction (for New Mexico Only) . |
| 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) Note: Refer to the Medical Policy titled Breast Reconstruction (for New Mexico Only) . |
| 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) |
| 17999 | Unlisted procedure, skin, mucous membrane and subcutaneous tissue |
| 19316 | Mastopexy |
| 19325 | Breast augmentation with implant |

| CPT/HCPCS Code | Description |
|---|---|
| The following codes may be Cosmetic; review is required to determine if considered Cosmetic or Reconstructive. | |
| 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 |
| 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 than 80 sq cm |
| 21208 | Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant) |
| 21209 | Osteoplasty, facial bones; reduction |
| 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) |
| 21248 | Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial |
| 21249 | Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete |
| 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 |
| 21275 | Secondary revision of orbitocraniofacial reconstruction |
| 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 |
| 21299 | Unlisted craniofacial and maxillofacial procedure |

| CPT/HCPCS Code | Description |
|---|---|
| The following codes may be Cosmetic; review is required to determine if considered Cosmetic or Reconstructive. | |
| 28344 | Reconstruction, toe(s); polydactyly |
| 30540 | Repair choanal atresia; intranasal |
| 30545 | Repair choanal atresia; transpalatine |
| 30620 | Septal or other intranasal dermatoplasty (does not include obtaining graft) |
| L8600 | Implantable breast prosthesis, silicone or equal |
| L8607 | Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies |
| Q2026 | Injection, Radiesse, 0.1 ml |
| Q2028 | Injection, sculptra, 0.5 mg |
| The following codes are considered cosmetic; the codes do not improve a Functional, Physical, or physiological Impairment. | |
| 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 |
| 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 4 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 |
| 17380 | Electrolysis epilation, each 30 minutes |
| 21270 | Malar augmentation, prosthetic material |
| 69090 | Ear piercing |
| 69300 | Otoplasty, protruding ear, with or without size reduction |
| J0591 | Injection, deoxycholic acid, 1 mg |

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Description of Services

Reconstructive Procedures treat a physical and/or physiological abnormality related to an injury, illness, development abnormality, or congenital anomaly to improve or restore physiologic function. Whereas Cosmetic Procedures are performed to reshape or enhance appearance without improving physiological function. [American Society of Plastic

Benefit Considerations

Some states require benefit coverage for services that UnitedHealthcare considers Cosmetic Procedures, such as repair of external congenital anomalies in the absence of a Functional Impairment. Refer to the federal, state, and contractual requirements.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Many cosmetic and reconstructive interventions are surgical procedures and are not subject to FDA approval. However, devices and instruments used during the procedures may require FDA approval. Refer to the following website for additional information: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed January 16, 2024)

References

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Centers for Disease Control and Prevention. (2023, February 23). *Facts about anotia/microtia*. The Center for Disease Control and Prevention. Available at: <https://www.cdc.gov/ncbddd/birthdefects/anotia-microtia.html>. Accessed January 16, 2024.

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UnitedHealthcare Insurance Company Generic Certificate of Coverage 2018.

Policy History/Revision Information

| Date | Summary of Changes |
|------------|--|
| 01/01/2025 | Applicable Codes <ul style="list-style-type: none">Updated list of applicable CPT codes to reflect annual edits; removed 15819 Supporting Information <ul style="list-style-type: none">Archived previous policy version CS027NM.B |

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the

independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.