	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12
	<i>Subject</i> Cosmetic and Reconstructive Services	<i>Effective Date</i>	04/01/2025
<i>Approval Date</i>		01/21/2025	
<i>Supersedes Date</i>		04/01/2024	
		<i>Page</i>	1 of 15

This document applies to the following Participating Organizations:

EHP
 Johns Hopkins Advantage MD
 Johns Hopkins Health Plan of Virginia Inc. (JHPVA)
 Priority Partners
 US Family Health Plan

Keywords: Cosmetic, Cosmetic and Reconstructive Services, Reconstructive Services

Table of Contents	Page Number
I. ACTION	1
II. POLICY DISCLAIMER	1
III. POLICY	1
IV. POLICY CRITERIA	2
V. DEFINITIONS	6
VI. CODING DISCLAIMER	7
VII. CODING INFORMATION	7
VIII. REFERENCE STATEMENT	13
IX. REFERENCES	13
X. APPROVALS	15

I. ACTION

	New Policy	
X	Revising Policy Number	CMS03.12
	Superseding Policy Number	
	Retiring Policy Number	

II. POLICY DISCLAIMER

Johns Hopkins Health Plans (JHHP) provides a full spectrum of health care products and services for Advantage MD, Employer Health Programs, Johns Hopkins Health Plan of Virginia Inc., Priority Partners, and US Family Health Plan. Each line of business possesses its own unique contract, benefits, regulations, and regulators' clinical guidelines that supersede the information outlined in this policy.

III. POLICY

For Advantage MD refer to: [Medicare Coverage Database](#)

- National Coverage Determination (NCD) [140.2 Breast Reconstruction Following Mastectomy](#)
- National Coverage Determination (NCD) [250.5 Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome \(LDS\)](#)
- Local Coverage Determination (LCD) [L35090 Cosmetic and Reconstructive Surgery](#)
- Local Coverage Determination (LCD) [L35004 Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow](#)
- Local Coverage Determination (LCD) [L34938 Removal of Benign Skin Lesions](#)

 JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12
	<i>Subject</i> Cosmetic and Reconstructive Services	<i>Effective Date</i>	04/01/2025
		<i>Approval Date</i>	01/21/2025
		<i>Supersedes Date</i>	04/01/2024
		<i>Page</i>	2 of 15

For Employer Health Programs (EHP) refer to:

- Plan specific Summary Plan Descriptions (SPDs)

For Johns Hopkins Health Plan of Virginia Inc. (JHHPVA) refer to [Medicare Coverage Database](#)

- National Coverage Determination (NCD) [140.2 Breast Reconstruction following Mastectomy](#)
- National Coverage Determination (NCD) [250.5 Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome \(LDS\)](#)
- Local Coverage Determination (LCD) [L33428 Cosmetic and Reconstructive Surgery](#)
- Local Coverage Determination (LCD) [L34411 Blepharoplasty, Eyelid Surgery and Brow Lift](#)
- Local Coverage Determination (LCD) [L33445 Removal of Benign and Malignant Skin Lesions](#)

For Priority Partners (PPMCO) refer to: [Code of Maryland Regulations \(COMAR\)](#)

- Code of Maryland Regulations (COMAR) 10.67.06.26-2 [Plastic and Restorative Surgery](#)
- Code of Maryland Regulations (COMAR) 10.67.06.27 [Benefits - Limitations](#)

For US Family Health Plan, refer to: [TRICARE Policy Manuals](#)

- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 1, Section 1.2 Exclusions
- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 4, Section 2.1 Cosmetic, Reconstructive, and Plastic Surgery-General Guidelines
- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 4, Section 3.1 Laser Surgery
- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 4, Section 5.2 Post-Mastectomy Reconstructive Breast Surgery and Breast Prostheses
- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 4, Section 5.3 Prophylactic Mastectomy, Prophylactic Oophorectomy, and Prophylactic Hysterectomy
- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 4, Section 5.4 Reduction Mammoplasty for Macromastia
- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 4, Section 5.5 Silicone or Saline Breast Implant Removal
- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 4, Section 5.6 Breast Reconstruction as a Result of Congenital Anomaly
- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 4, Section 5.7 Gynecomastia
- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 4, Section 7.1 Oral Surgery
- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 7, Section 17.1 Dermatological Procedures-General
- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 8, Section 13.1 Adjunctive Dental Care


IV. POLICY CRITERIA

A. General Considerations:

- Reconstructive surgical procedures are considered medically necessary when performed to improve/restore bodily function or approximate normal appearance resulting from disease, trauma, certain congenital defects, or previous therapeutic interventions.
- In cases where a surgery may have both a cosmetic and reconstructive component (examples: reduction mammoplasty, orthognathic surgery, septoplasty/nasal septum repair), clinical documentation including the history and physical exam report, pathology report and preoperative photographs will be medically reviewed by the Plan to determine whether the procedure is primarily reconstructive or cosmetic.

	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12	
		<i>Effective Date</i>	04/01/2025	
		<i>Approval Date</i>	01/21/2025	
	<i>Subject</i>	Cosmetic and Reconstructive Services	<i>Supersedes Date</i>	04/01/2024
			<i>Page</i>	3 of 15

3. When a systemic complication such as sepsis, infection, hemorrhage or other serious documented medical complication occurs as a result of any surgical procedure, treatment of the complication is considered medically necessary.
 4. This policy does not address procedures related to gender-affirming care. Refer to JHHP Medical Policy [CMS07.05 Gender Affirmation Treatment & Procedures](#) OR [CMS24.08 Gender Affirming Treatment & Procedures - EHP](#) for services related to gender-affirming care.
- B. When benefits are provided under the member's contract, Johns Hopkins Health Plans (JHHP) consider the following services medically necessary when the criteria listed are met:
1. Autologous Fat Grafting:
 - a. Correction of deformity secondary to congenital disease (e.g., hemifacial microsomia) or trauma; OR,
 - b. Coverage of fat grafting for breast reconstruction after mastectomy.
 2. Brow & Eyelid Surgery: (Blepharoplasty, Ptosis Repair, Eyelid Reconstruction, Eyelid Lesion Excision, Ectropion and/or Entropion Repair):
 - a. When InterQual[®] criteria are met.
 3. Breast Implants:
 - a. When InterQual[®] criteria are met for:
 - i. Reconstruction of breast post-mastectomy or lumpectomy due to malignant neoplasm of female breast; OR,
 - ii. Reconstruction of the breast secondary to congenital anomaly or trauma with severe breast disfigurement; OR,
 - iii. Breast implant removal.
 4. Breast Reconstruction:
 - a. When InterQual[®] criteria are met
 - b. For external breast prostheses, see Medical Policy [CMS16.18 Prosthetic Devices](#)
 5. Breast Reduction: (Male/Female):
 - a. When InterQual[®] criteria are met.
 6. Chemical Peel:
 - a. See Medical Policy [CMS16.02 Treatment of Skin Conditions](#)
 7. Chin Implant, Genioplasty (surgery of the chin):
 - a. For correction of deformity secondary to disease or trauma.
 8. Collagen Implants:
 - a. To correct an anomaly or functional impairment resulting from trauma, therapeutic intervention (e.g., surgery), or disease (including disfiguring scarring post acne), such as:
 - i. Post-removal of disfiguring birthmarks/moles.
 - ii. Craniofacial malformations, including hypertelorism (excessive width between orbits).
 - iii. Cleft lip/cleft palate.
 9. Cutaneous Vascular Lesion Destruction:
 - a. See Medical Policy [CMS16.02 Treatment for Skin Conditions](#)
 10. Dermabrasion:
 - a. See Medical Policy [CMS16.02 Treatment of Skin Conditions](#)
 11. Dermal Injectable Fillers (e.g., Sculptra[®] or Radiesse[®]):
 - a. For the treatment of photographically documented facial lipodystrophy syndrome caused by antiretroviral therapy in HIV-infected persons.
 12. Hair Removal:

	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12	
		<i>Effective Date</i>	04/01/2025	
		<i>Approval Date</i>	01/21/2025	
	<i>Subject</i>	Cosmetic and Reconstructive Services	<i>Supersedes Date</i>	04/01/2024
			<i>Page</i>	4 of 15

- a. In instances where skin flaps for reconstruction require removal of hair (e.g., forehead flap for nasal reconstruction).
- b. For the treatment of recurrent pilonidal cysts previously treated with surgery.
- c. See Medical Policy [CMS16.02 Treatment for Skin Conditions](#)
13. Hair Transplant or Hairplasty:
 - a. When it is performed to correct permanent hair loss that is caused by disease or injury (e.g., eyebrow(s), eyelashes following a burn injury, or asymmetric hairline replacement following a burn injury).
14. Keloid Treatment:
 - a. See Medical Policy [CMS16.02 Treatment for Skin Conditions](#)
15. Lipectomy/Liposuction:
 - a. For the treatment of lymphedema when there is documented failure of the following:
 - i. Standard conservative therapies (e.g., manual lymph and pressure therapy); AND,
 - ii. Microsurgical reconstruction involving lympho-venous shunts and transplantation of lymph vessels or nodes when supported by imaging (e.g., ICG lymphography, MR lymphangiography, or ultrasonography) to provide reduction of lymphedema.
 - b. For the treatment of hyperhidrosis/bromhidrosis via axillary sweat gland excision when refractory to management with nonsurgical options (e.g., oral medications, topical medications).
 - c. When liposuction is considered integral to the primary procedure (e.g., breast reconstruction).
16. Mastectomy, Prophylactic:
 - a. When InterQual[®] criteria are met (*Refer to section 4. Breast Reconstruction for concurrent breast reconstruction*)
17. Mastopexy:
 - a. When InterQual[®] criteria are met.
18. Neck Lift:
 - a. For the treatment of disease or trauma.
19. Orthognathic Surgery (*Refer to Definitions*):(Bone Augmentation of Mandible & Maxilla, Arthroscopy, Arthroplasty & Reconstruction of the Temporomandibular Joint, Osteotomy of Anterior Segment of the Mandible & Maxilla, LeFort I Osteotomy, Sagittal Split Osteotomy, Maxillary Buttress Osteotomy):
 - a. When performed to correct a severe, handicapping skeletal malocclusion or oral-facial deformities contributing to significant functional impairment (e.g., persistent difficulties with mastication and swallowing, malnutrition, speech dysfunction, persistent myofascial pain, obstructive sleep apnea); AND,
 - b. InterQual[®] criteria are met.
20. Panniculectomy:
 - a. See Medical Policy [CMS03.08 Panniculectomy](#)
21. Pectoral Implants:
 - a. When done in conjunction with breast reconstruction for medical indications such as: mastectomy due to malignant neoplasm of female breast or trauma, or in congenital absence (Poland Syndrome).
22. Pectus Deformity Repair (Pectus Carinatum, Pectus Excavatum):
 - a. When InterQual[®] criteria are met.
23. Phalloplasty:
 - a. For reconstructive surgery post-trauma or for the treatment of disease (e.g., bladder or cloacal exstrophy, penile cancer, penile necrosis).
24. Rhinophyma Surgery:
 - a. For the treatment of bleeding or infection refractory to medical therapy (i.e., the need for repeated cautery of bleeding telangiectasias or frequent courses of antibiotics for pustular eruptions).
25. Rhinoplasty:

	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12	
		<i>Effective Date</i>	04/01/2025	
		<i>Approval Date</i>	01/21/2025	
	<i>Subject</i>	Cosmetic and Reconstructive Services	<i>Supersedes Date</i>	04/01/2024
			<i>Page</i>	5 of 15

- a. When InterQual[®] criteria are met.
 26. Rhytidectomy (face lift):
 - a. For the treatment of disease or trauma (e.g., facial paralysis or burns).
 27. Sclerotherapy:
 - a. See Medical Policy [CMS22.01 Minimally Invasive Treatments of Varicosities](#).
 28. Septoplasty:
 - a. When InterQual[®] criteria are met.
 29. Tattooing:
 - a. Nipple tattooing post-mastectomy; OR,
 - b. Tattooing of glans post-penile reconstruction due to disease or trauma; OR,
 - c. Following trauma or removal of cancer from an eyelid, eyebrow or lip(s).
 30. Tattoo Removal:
 - a. See Medical Policy [CMS16.02 Treatment for Skin Conditions](#).
 31. Tissue Expanders:
 - a. For absence or deformity resulting from trauma, disease or congenital anomaly.
- C. Unless benefits are provided under the member's contract, JHHP considers the following services cosmetic and, therefore, not medically necessary unless specific criteria listed above are met (*The list is not all-inclusive*):
1. Abdominoplasty
 2. Brachioplasty
 3. Breast Reconstruction for tuberous/tubular breasts
 4. Buttock Lift/Thigh Lift
 5. Chest and Back Contouring
 6. Diastasis Recti Repair
 7. Ear or Body Piercing
 8. Face Lift (Rhytidectomy)
 9. Frown Line Treatments/Surgery
 10. Hair Transplant/Hairplasty
 11. Lip Augmentation
 12. Liposuction
 13. Otoplasty
 14. Pectoral Implants for the sole purpose of augmentation of chest size
 15. Penile Augmentation
 16. Phalloplasty
 17. Radiesse[®] Injections (volumizing filler for wrinkle reduction)
 18. Tissue Expanders when used to change the size or contour of body structure in the absence of trauma, disease or congenital condition.
- D. Unless benefits are provided under the member's contract, JHHP considers the following services investigational as they do not meet the Technology Assessment Criteria (TEC) per [CMS01.00 Medical Policy Introduction](#) (*The list is not all-inclusive*):
1. Autologous fat transplantation for the purpose of implanting adipose-derived stem cells.
 2. Treatment of pectus excavatum with the following:
 - a. The magnetic mini-mover procedure
 - b. The vacuum bell
 - c. Dynamic Compression System.

	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12	
		<i>Effective Date</i>	04/01/2025	
		<i>Approval Date</i>	01/21/2025	
	<i>Subject</i>	Cosmetic and Reconstructive Services	<i>Supersedes Date</i>	04/01/2024
			<i>Page</i>	6 of 15

V. DEFINITIONS

Cosmetic:

- COMAR 10.67.06.27 Benefits — Limitations: Cosmetic surgery when performed solely to maintain a normal physical appearance or enhance beyond average level toward an aesthetic ideal.
- TRICARE Policy Manual 6010.63-M, April 2021, Chapter 4, Section 2.1 Cosmetic, Reconstructive, and Plastic Surgery – General Guidelines: Cosmetic, reconstructive, and/or plastic surgery is defined as surgery or treatments (including procedures, drugs, and devices) which can be expected primarily to improve the physical appearance of a beneficiary, and/or which is performed primarily for psychological purposes, and/or which restores form, but does not correct or materially improve a bodily function.
- CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 16, Section 120 Cosmetic Surgery: Cosmetic surgery or expenses incurred in connection with such surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of an accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.

Medical Necessity:

- COMAR 10.67.01.01 – Definitions. "Medically necessary" means that the service or benefit is:
 - Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
 - Consistent with current accepted standards of good medical practice;
 - The most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and,
 - Not primarily for the convenience of the consumer, the consumer's family, or the provider.
- TRICARE Operations Manual 6010.63-M, April 2021. Medical Necessity Determination: A review to determine if the recommended health care services are reasonable for the diagnosis and treatment of illness, injury, pregnancy, mental disorders and adequate for well-baby care.
- CMS, Medically necessary: Services or supplies that are proper and needed for the diagnosis or treatment of a medical condition; are provided for the diagnosis, direct care, and treatment of a medical condition; meet the standards of good medical practice in the local area, and aren't mainly for the convenience.


Orthognathic Surgery: A class of surgical procedures designed to realign the maxillofacial skeletal structures with each other and with the other craniofacial structures. This surgery usually involves the maxilla and/or mandible, but other bony components may be involved as well.

Reconstructive Surgeries: Are those operative procedures performed on structures of the body to improve/restore bodily function or normal appearance resulting from disease, trauma, certain congenital defects, or previous therapeutic intervention. Reconstructive surgical procedures are considered medically necessary.

Technology Assessment: The systematic evaluation of the properties, effects and/or impacts of health technologies and interventions. It covers both the direct intended consequences of technologies and interventions, and their indirect unintended consequences (World Health Organization, 2018).

Technology Evaluation Criteria (TEC): A service, device or supply must meet all the following criteria:

1. The technology must have final approval from the appropriate government regulatory bodies for intended use.

	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12	
		<i>Effective Date</i>	04/01/2025	
		<i>Approval Date</i>	01/21/2025	
	<i>Subject</i>	Cosmetic and Reconstructive Services	<i>Supersedes Date</i>	04/01/2024
			<i>Page</i>	7 of 15

2. There must be sufficient scientific evidence-based studies to permit conclusions concerning the effect of technology on health outcomes.
3. The technology must improve the member's net health outcome.
4. The technology must be as beneficial as any established alternatives.
5. The improvement must be attainable outside the investigational setting.

VI. CODING DISCLAIMER

CPT® Copyright 2025 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

Note: The following CPT/HCPCS codes are included below for informational purposes and may not be all-inclusive. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member's specific benefit plan document 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 of payment. Other policies and coverage determination guidelines may apply.

Note: All inpatient admissions require pre-authorization.

Adherence to the provisions in this policy may be monitored and addressed through post payment data analysis and/or medical review audits

Advantage MD: Regulatory guidance supersedes JHHP Medical Policies. If there are no statutes, regulations, NCDs, LCDs, or LCAs, or other CMS guidelines, apply the Medical Policy criteria.

Employer Health Programs (EHP): Specific Summary Plan Descriptions (SPDs) supersedes JHHP Medical Policy. If there are no criteria in the SPD, apply the Medical Policy criteria.

Johns Hopkins Health Plan of Virginia Inc. (JHHPVA): Regulatory guidance supersedes JHHP Medical Policies. If there are no statutes, regulations, NCDs, LCDs, or LCAs, or other CMS guidelines, apply the Medical Policy criteria.

Priority Partners (PPMCO): Regulatory guidance supersedes JHHP Medical Policy. If there are no criteria in COMAR regulations, or other State guidelines, apply the Medical Policy criteria.

US Family Health Plan (USFHP): Regulatory guidance supersedes JHHP Medical Policy. If there are no TRICARE policies, or other regulatory guidelines, apply the Medical Policy criteria.

VII. CODING INFORMATION

CPT® CODES ARE FOR INFORMATIONAL PURPOSES	
CPT® CODES	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)

 JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12
		<i>Effective Date</i>	04/01/2025
		<i>Approval Date</i>	01/21/2025
	<i>Subject</i>	<i>Supersedes Date</i>	04/01/2024
	Cosmetic and Reconstructive Services	<i>Page</i>	8 of 15


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
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
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
15819	Cervicoplasty
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
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

	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12	
		<i>Effective Date</i>	04/01/2025	
		<i>Approval Date</i>	01/21/2025	
	<i>Subject</i>	Cosmetic and Reconstructive Services	<i>Supersedes Date</i>	04/01/2024
			<i>Page</i>	9 of 15


15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
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)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
19316	Mastopexy
19318	Breast reduction
19325	Mammoplasty, augmentation; with prosthetic implant
19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19340	Insertion of breast implant on same day of mastectomy (i.e immediate)
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant
19364	Breast reconstruction with free flap
19367	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;
19368	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site; with microvascular anastomosis (supercharging)
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast
19396	Preparation of moulage for custom breast implant
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece

 JOHNS HOPKINS <small>HEALTH PLANS</small>	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12
		<i>Effective Date</i>	04/01/2025
		<i>Approval Date</i>	01/21/2025
	<i>Subject</i> Cosmetic and Reconstructive Services	<i>Supersedes Date</i>	04/01/2024
		<i>Page</i>	10 of 15

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)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
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
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, 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 (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I
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 (eg, 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)

 JOHNS HOPKINS <small>HEALTH PLANS</small>	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12
		<i>Effective Date</i>	04/01/2025
		<i>Approval Date</i>	01/21/2025
	<i>Subject</i> Cosmetic and Reconstructive Services	<i>Supersedes Date</i>	04/01/2024
		<i>Page</i>	11 of 15

21181	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial
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
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
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
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21198	Osteotomy, mandible, segmental;
21199	Osteotomy, mandible, segmental; with genioglossus advancement
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21215	Graft, bone; mandible (includes obtaining graft)
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)
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
21242	Arthroplasty, temporomandibular joint, with allograft
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, 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) (eg, for hemifacial microsomia)
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete

	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12	
		<i>Effective Date</i>	04/01/2025	
		<i>Approval Date</i>	01/21/2025	
	<i>Subject</i>	Cosmetic and Reconstructive Services	<i>Supersedes Date</i>	04/01/2024
			<i>Page</i>	12 of 15

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) (eg, 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 (eg, for treatment of benign masseteric hypertrophy); extraoral approach
21296	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach
21490	Open treatment of temporomandibular dislocation
21497	Interdental wiring, for condition other than fracture
21740	Reconstructive repair of pectus excavatum or carinatum; open
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)
29804	Arthroscopy, temporomandibular joint, surgical
30120	Excision or surgical planing of skin of nose for rhinophyma
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)

	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12	
		<i>Effective Date</i>	04/01/2025	
		<i>Approval Date</i>	01/21/2025	
	<i>Subject</i>	Cosmetic and Reconstructive Services	<i>Supersedes Date</i>	04/01/2024
			<i>Page</i>	13 of 15

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
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous 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 (eg, Fasanella-Servat type)
67914	Repair of ectropion; suture
67915	Repair of ectropion; thermocauterization
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (eg, tarsal strip operations)
67921	Repair of entropion; suture
67922	Repair of entropion; thermocauterization
67923	Repair of entropion; excision tarsal wedge
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)
69090	Ear piercing
69300	Otoplasty, protruding ear, with or without size reduction

VIII. REFERENCE STATEMENT

Analyses of the scientific and clinical references cited below were conducted and utilized by the Johns Hopkins Health Plans (JHHP) Medical Policy Team during the development and implementation of this medical policy. The Medical Policy Team will continue to monitor and review any newly published clinical evidence and revise the policy and adjust the references below accordingly if deemed necessary.


IX. REFERENCES

Aetna. (2024, April 6). *Cosmetic Surgery and Procedures*. Medical Clinical Policy Bulletins: 0031. <https://www.aetna.com>

Aetna. (2024, March 25). *Orthognathic Surgery*. Medical Clinical Policy Bulletins: 0095. <https://www.aetna.com>

American Society for Aesthetic Plastic Surgery (ASAPS). (2023). *Aesthetic Plastic Surgery Statistics*. <https://www.theaestheticsociety.org/>

American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS). (2023). *Procedures and Treatments*. <https://www.asoprs.org/>

 JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12	
		<i>Effective Date</i>	04/01/2025	
		<i>Approval Date</i>	01/21/2025	
	<i>Subject</i>	Cosmetic and Reconstructive Services	<i>Supersedes Date</i>	04/01/2024
			<i>Page</i>	14 of 15

American Society of Plastic Surgeons (ASPS). (2024). *ASPS Recommended Insurance Coverage Criteria for Third-Party Payers*. <https://www.plasticsurgery.org/>

Ashinoff, R.L. & Chang, E.I. (2024). Lower extremity lymphedema. *UpToDate*. Retrieved December 20, 2024, from <https://www.uptodate.com/>

Carruthers, J. & Humphrey, S. (2024). Injectable soft tissue fillers: Overview of clinical use. *UpToDate*. <https://www.uptodate.com>

Cigna. (2024, May 15). *Injectable Fillers*. Medical Coverage Policy #0511. <https://static.cigna.com/>

Cigna. (2024, April 15). *Surgical Treatment of Chest Wall Deformities*. Medical Coverage Policy #0309. <https://static.cigna.com>

Glesby, M.J. (2024) Treatment of HIV-associated lipodystrophy. *UpToDate*. <https://www.uptodate.com>

Heidekrueger, P., Juran, S., Patel, A., Tanna, N., & Broer, P.N. (2016). Plastic Surgery Statistics in the US: Evidence and Implications. *Aesthetic Plastic Surgery*, 40 (2):293-300. <https://doi.org/10.1007/s00266-016-0611-3>

Humana (202, March 28). *Cosmetic and Reconstructive Surgery*. Medical Coverage Policy #HUM-0345-045. <https://apps.humana.com/>

Leon-Villalpos, J. & Dziejwski, P. (2024). Overview of surgical procedures used in the management of burn injuries. *UpToDate*. <https://www.uptodate.com>

Maier, L. (2024). Management of rosacea. *UpToDate*. <https://www.uptodate.com>

Mayer, O. H. (2024) Pectus excavatum: Treatment. *Uptodate*. Retrieved December 20, 2024, from <https://www.uptodate.com>

Mehrra, B., Ashinoff, R.L., & Chang, E.I. (2024). Surgical treatment of primary and secondary lymphedema. *UpToDate*. Retrieved December 20, 2024, from <https://www.uptodate.com/>

Nahabedian, M. & Brooks, D. (2024). Rectus abdominis diastasis. *UpToDate*. Retrieved December 22, 2024, from: <https://www.uptodate.com>

Nawrocki, S. & Cha, J. (2019). The etiology, diagnosis, and management of hyperhidrosis: A comprehensive review: Therapeutic options. *Journal of the American Academy of Dermatology*, 81(3):669-680. <https://doi.org/10.1016/j.jaad.2018.11.066>

Schaverien, M.V., Munnoch, D.A., & Brorson, H. (2018). Liposuction Treatment of Lymphedema. *Seminars in Plastic Surgery*, 32(1):42-47. <https://doi.org/10.1055/s-0038-1635116>

Stuart, M.E., Strite, S.A., & Gillard, K.K. (2020). A systematic evidence-based review of treatments for primary hyperhidrosis. *Journal of Drug Assessment*, 10(1):35-50. <https://doi.org/10.1080/21556660.2020.1857149>

Thomas, M.M. & Houreld, N.N. (2019). The "in's and outs" of laser hair removal: a mini review. *Journal of Cosmetic and Laser Therapy*, 21(6):316-322. <https://doi.org/10.1080/14764172.2019.1605449>

 JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans Medical Policy Manual Medical Policy	<i>Policy Number</i>	CMS03.12
	<i>Subject</i> Cosmetic and Reconstructive Services	<i>Effective Date</i>	04/01/2025
		<i>Approval Date</i>	01/21/2025
		<i>Supersedes Date</i>	04/01/2024
		<i>Page</i>	15 of 15

X. APPROVALS

Historical Effective Dates: 06/03/2016, 03/03/2017, 09/01/2017, 08/02/2020, 08/02/2021, 02/01/2022, 05/01/2023, 11/1/2023, 04/01/2024, 04/01/2025