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Cosmetic and Reconstructive Procedures
Corporate Medical Policy

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Description/Summary

Cosmetic and reconstructive procedures may range from entirely cosmetic to entirely reconstructive. It is understood that there may be an area of overlap where cosmetic procedures have a reconstructive component, and reconstructive procedures have a cosmetic component.

These procedures are categorized, and benefits authorized, based upon the fundamental purpose of the procedure. The American Medical Association and the American Society of Plastic Surgeons have agreed upon the following definitions:

- Cosmetic procedures are those that are performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.
- Reconstructive procedures are those procedures performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function but may also be done to approximate a normal appearance.

To be considered medically necessary, the goal of reconstructive surgery must be to correct an abnormality in order to restore physiological function to the extent possible. As such, for reconstructive surgery to be considered medically necessary there must be a reasonable expectation that the procedure will improve the functional impairment. A procedure is considered cosmetic if the only desired and/or expected benefits would be emotional or psychological, unless to repair a genetic defect.

Requests for procedures listed in this policy should be accompanied by the following documentation:

- The name and date of the proposed surgery
- Preoperative photographs, if appropriate
- Date of accident or injury, if applicable

- History of present illness and/or conditions including diagnoses
- Documentation of functional impairment, pain or significant anatomic variance
- How the treatment can be reasonably expected to improve the functional impairment
- If applicable, the description of and CPT® coding for planned staged procedures following acute repair or initial primary repair
- Any additional information listed as indicated for the specific procedures listed below

If the intended service relates to gender affirming services, refer to the Blue Cross VT Gender Affirming Services Corporate Medical Policy.

If the intended service relates to the breast, refer to the Blue Cross VT Breast Surgery and Breast Prosthesis Corporate Medical Policy.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.
Attachment I – Coding Table

General Guidelines

Correction or Repair of Complications of a Cosmetic Procedure:
Blue Cross VT will review procedures intended to correct complications from a cosmetic procedure, regardless of if the original cosmetic procedure was medically necessary or if it was a non-covered service. In order for these corrections or repairs to be considered **medically necessary**, the subsequent surgery needs to be primarily reconstructive in nature. The purpose of the surgery should generally be performed to improve function but may also be done to approximate normal appearance.

Congenital Deformities in Children:
Procedures to correct congenital and developmental deformities in children are considered **medically necessary** when defects are severe or debilitating. These include cleft lip, cleft palate or both, and additional defects of the septum related to other cleft deformities, deforming hemangiomas, pectus excavatum, among others. See policy for further specifics on each body part. To receive benefits, the patient does not need to have been covered under a Blue Cross VT plan at time of birth.

EYES

Blepharoplasty, **Blepharoptosis Repair** and **Brow Ptosis Repair** - surgery of the eyelid and/or eyebrow and forehead.

Supporting Documentation Requested:
- Automated visual field study comparing taped to un-taped visual fields, including interpretation and report

- Preoperative photographs - one full-frontal view with patient looking directly at the camera. If a combination of blepharoplasty and brow ptosis repair is requested, a photograph with forehead manually lifted to demonstrate that brow ptosis repair alone will not resolve the visual impairment

Blepharoplasty, blepharoptosis repair or brow ptosis repair may be considered **medically necessary** for **ANY** of the following:

- Visual field testing, before and after manual elevation of the upper eyelid(s), is demonstrated by ONE of the following:
  - There is a difference of ≥ 12 degrees
  - There is at least a 30 % superior visual field difference; **OR**
- Frontal photograph noting 50% coverage of pupil by upper eyelid; **OR**
- For brow ptosis repair, frontal photograph showing eyebrow below the upper orbital rim; **OR**
- Repair to address trauma and procedure meets the definition of reconstructive.

NOTE: Approval will be for bilateral upper eyelids if both eyes meet criteria.

Blepharoplasty, blepharoptosis repair and repair of brow ptosis is **not medically necessary** when the above criteria are not met.

The following is considered cosmetic and therefore **not covered as a benefit exclusion**:

- Blepharoplasty, blepharoptosis repair or repair of brow ptosis, when performed only to improve the patient's appearance and self-esteem

Lateral Canthopexy

Lateral canthopexy may be considered **medically necessary** for the following:

- As a part of facial reconstruction after accidental injury, trauma, disease (e.g. infection) or congenital anomaly.

Lateral canthopexy is considered cosmetic and therefore **not covered as a benefit exclusion** when completed for the following reasons:

- To fix eyelids that droop or sag due to sun damage
- To fix eyelids that droop or sag due to aging

HEAD

Malar Augmentation with Prosthetic Material

Supporting Documentation Requested:

- History of present illness and history and physical report demonstrating physical impairment caused by disease, trauma, and/or congenital defect

Malar augmentation with prosthetic material may be considered **medically necessary** for **ANY** of the following:

- As part of facial reconstruction after accidental injury, trauma, or disease

(e.g. infection, tumor of the face); **OR**
- To correct a significant congenital anomaly

Malar augmentation with prosthetic material is considered cosmetic and therefore **not covered as a benefit exclusion** for all other indications.

Orthognathic Procedures

Supporting Documentation Requested:
- History of present illness and history and physical report demonstrating physical impairment caused by disease, trauma, and/or congenital defect
- Pictures and x-rays illustrating the deformity, both frontal and profile
- Additionally, for those under 18 years of age, one of the following must be submitted as evidence of puberty completion:
    - Documented tanner stage IV or V for members aged 15-18; **AND**
    - Stable height measurements for 6 months; **OR**
    - Puberty completion as shown on wrist radiograph

Orthognathic procedures may be considered **medically necessary** for **ANY** of the following:
- Prognathism or micrognathism with documented severe handicapping malocclusion with any of the following:
    - Deep impinging overbite with severe soft tissue damage
    - Impacted permanent anterior teeth
    - Class III malocclusion
    - Overjet of at least 4 mm
    - Overbite of at least 2 mm
    - Difficulty chewing or biting food
    - Difficulty swallowing
    - Open bite (space between the upper and lower teeth when the mouth is closed)
    - Inability to make lips meet without straining
    - Severe mandibular atrophy
- Diagnosis of Crouzon's syndrome
- Diagnosis of Treacher Collins' dysostosis
- Diagnosis of Romberg's Disease with severe facial deformity
- Other significant cranio-facial abnormalities related to structure and growth or trauma that include:
    - Cleft palate deformities
    - Other birth defects
    - Severe traumatic deviations causing severe handicapping malocclusion referenced above

LeFort osteotomy, used alone or in combination with other orthognathic procedures, may be considered **medically necessary** for **ANY** of the following:
- Correction of midface deformities due to trauma or congenital anomalies
- Treatment of Class II and Class III malocclusions

Orthognathic procedures are considered cosmetic and therefore **not covered as a benefit exclusion** for the following:

- In the absence of severe handicapping malocclusion, trauma, congenital anomalies not listed above
- When intended to reshape normal structures of the body in order to improve the patient's appearance and self-esteem

NOTE: Mentoplasty/genioplasty for familial chin deformities or "weak chin" performed for cosmetic reasons are **not covered as they are a benefit exclusion.**

NOTE: Orthodontics, including orthodontics performed as adjunct to orthognathic surgery or in connection with an accidental injury **are not covered as they are a benefit exclusion**, even if the orthognathic procedure is medically necessary.

Otoplasty – Reconstruction of external auditory canal

Supporting Documentation Requested:

- History and physical examination
- Photographs

Otoplasty procedures may be considered **medically necessary** for **ANY** of the following:

- Surgically correctable congenital malformation, trauma, surgery, infection, or other process that is causing hearing loss. [Audiogram must demonstrate a loss of at least 15 decibels in the affected ear(s)
- To restore a significantly abnormal external ear or auditory canal related to trauma, tumor, surgery, infection, or congenital malformation (e.g. atresia)
- Congenital absence (anotia) or underdevelopment of the external ear (microtia)

The following procedures are considered cosmetic and therefore **not covered as a benefit exclusion** for all other indications, including the following (not an all-inclusive list):

- Keloids and/or clefts
- To reshape the ear due to consequences of ear piercing or ear gauging in the absence of significant physical dysfunction
- "Lop ears" or protruding ears

Rhinoplasty/Septorhinoplasty – Surgery of The Nose

Supporting Documentation Requested:

- History of present illness and history and physical report
- Preoperative photographs -- one frontal view, one profile one view with head held back
- Date of previous surgery, if applicable
- Date of accident or injury, if applicable
- Name & location of the treating physician at the time of accident
- Emergency room or office records, including x-ray or x-ray reports, if available and

applicable

Rhinoplasty/Septorhinoplasty procedures may be considered **medically necessary** for **ANY** of the following:

- Airway obstruction from deformities due to disease, congenital abnormality, or trauma that will not or would not be expected to respond to medication therapy and will not respond to septoplasty alone; **OR**
- Immediate or planned-staged reconstruction following trauma, tumor, surgery or infection of the nose

Rhinoplasty/Septorhinoplasty procedures are considered cosmetic and therefore **not covered as a benefit exclusion** for the following:

- To reshape a functional nose in the absence of airway obstruction from deformities due to disease, congenital abnormality, previous therapy or trauma that will not or would not be expected to respond to medication therapy and will not respond to septoplasty alone and performed only to improve the patient's appearance and self-esteem
- To reshape the nose related to consequences of nose piercing or nose gauging
- To reshape the nose due to rhinophyma

For procedures related to temporomandibular joint dysfunction, refer to the Blue Cross VT Temporomandibular Joint Dysfunction Corporate Medical Policy.

For procedures related to obstructive sleep apnea, refer to the Blue Cross VT Sleep Disorders Diagnosis & Treatment Corporate Medical Policy.

SKIN

Bio-engineered Skin and Soft Tissue Substitutes (e.g. Hyalomatrix, AlloDerm, Apligraf, Epicel, etc.)
Refer to the Blue Cross VT Bio-Engineered Skin and Soft Tissue Substitutes Corporate Medical Policy

Cryotherapy for the Treatment of Acne Vulgaris

Supporting Documentation Requested:

- History of present illness and history and physical report
- Photograph demonstrating affected area

Cryotherapy may be considered **medically necessary** when **BOTH** of the following are met:

- Active acne
- Documented evidence of failure of a trial of topical retinoid treatment, topical antibiotic therapy, and oral antibiotic therapy

Cryotherapy procedures are considered **not medically necessary** when there has not been a trial of topical retinoid treatment, topical antibiotic therapy, and oral antibiotic therapy.

Cryotherapy procedures are considered cosmetic and therefore **not covered as a benefit exclusion** for the following:

- In the absence of active acne
- To remove acne scaring to improve the patient's appearance and self-esteem

Dermabrasion – Surgical procedure for removal of scars on the skin by using sandpaper or mechanical methods on the frozen epidermis.

Supporting Documentation Requested:

- History of present illness and history and physical report
- Date of accident or injury, if applicable
- Photograph demonstrating affected area

Dermabrasion may be considered **medically necessary** for **ANY** of the following:

- Restoration following previous injury or surgery with severe disfigurement or functional and physiological impairment
- Documented evidence of ten or more superficial basal cell carcinomas, actinic keratoses, or other pre-malignant skin lesions that have failed topical retinoid treatment, topical chemotherapeutic agents, and cryotherapy

Dermabrasion is considered **not medically necessary** for the treatment of all other conditions.

Dermabrasion is considered cosmetic and therefore **not covered as a benefit exclusion** to treat the following:

- Scarring from acne vulgaris
- Skin wrinkling
- Rhinophyma
- Tattoo Removal

Light Therapy for Psoriasis
Refer to the Blue Cross VT Light Therapy for Dermatologic Conditions Corporate Medical Policy

Photodynamic Therapy: Dermatological Applications - for the treatments of actinic keratosis, carcinomas of the skin and acne vulgaris
Refer to the Blue Cross VT Dermatologic Applications of Photodynamic Therapy Corporate Medical Policy.

Scar and Keloid Revision

Supporting Documentation Requested:

- History of present illness and history and physical report
- Preoperative photograph
- Date of accident or injury, if applicable

- Description of and CPT® coding for planned staged procedure following acute repair, within two years of previous stage or initial primary repair

Scar and Keloid Revision may be considered **medically necessary** for the following:

- To treat functional impairment or pain with the expectation that treatment can be reasonably expected to improve the impairment

Scar and Keloid Revision is considered cosmetic and therefore **not covered as a benefit exclusion** for the following:

- In the absence of any functional impairment, pain, or expectation that treatment can be reasonably expected to improve the impairment
- To correct any consequences related to piercing or gauging

Tattooing of the Skin

Supporting Documentation Requested:

- Clinical statement indicating tattooing is in conjunction with medically necessary procedures (e.g. nipple reconstruction post mastectomy)

Tattooing of the skin is considered **medically necessary** with approval of primary procedure (e.g. breast reconstruction following mastectomy)

Tattooing of the skin is considered cosmetic and therefore **not covered as a benefit exclusion in the following circumstances**:

- Placement, removal or coverage of decorative tattoos
- Tattooing of the skin for color differential as a result of vitiligo

*NOTE: No PA is required for tattooing of the skin for breast reconstruction when submitted with a diagnosis of breast cancer. Refer to the Blue Cross VT Breast Surgery and Breast Prosthesis Corporate Medical Policy

TORSO

Panniculectomy- removal of excess lower abdominal skin without fascia contouring, umbilical transposition, or liposuction

Supporting Documentation Requested:

- History of present illness and physical examination including weight values for the last six months
- Pre-operative photographs: one full-body anterior photograph of the patient standing straight and one photograph of the abdominal fold, raised to document any reported skin changes, e.g., dermatitis ulceration, and one lateral photograph

Panniculectomy may be considered **medically necessary** when the following criteria are met:

- The patient has had a documented massive weight loss (usually ≥ 100 lbs.); **AND**
- There is documentation of functional impairment due to pannus (difficulty with ambulation, ADLs, or inability to participate in a fitness program designed to maintain weight loss) **OR** chronic skin rashes, ulceration, or infection unresponsive to conventional medical treatment; **AND**
- Weight is documented stable for ≥ 6 months, and if weight loss is due to bariatric surgery, the member is ≥18 months post bariatric surgery

Panniculectomy and Abdominoplasty in the setting of Abdominal Wall Hernia and Reconstruction

Panniculectomy may be considered **medically necessary** when performed in connection with a clinically significant and medically necessary herniorrhaphy (hernia repair) **AND** the removal of the pannus is necessary to improve the integrity of the abdominal wall reconstruction.

Abdominoplasty may be considered **medically necessary** when performed in connection with a clinically significant and medically necessary herniorrhaphy (hernia repair) of such a severe degree as to require abdominal wall reconstruction **AND** the hernia is of such a seriousness that the procedure is necessary to improve the integrity of the abdominal wall reconstruction.

Abdominoplasty and panniculectomy is considered cosmetic and therefore **not covered as a benefit exclusion** when performed in the absence of functional impairment and only intended to improve the patient's appearance and self-esteem.

Pectus Excavatum or Pectus Carinatum Repair - reconstruction/repair of chest wall deformity in children up to 18 years old.

Supporting Documentation Requested:
- History and physical examination
- Frontal and side photographs of chest
- Statement from physician delineating cardiovascular and pulmonary risk

Pectus Excavatum or Pectus Carinatum Repair may be considered **medically necessary** for **ANY** of the following:
- A Haller index of 3.2 or greater (which is suggested to be a future predictor of cardiovascular compromise) for pectus excavatum
- When based upon the requesting physician's clinical judgement the magnitude of the deformity places the patient at risk of impending cardiovascular or respiratory compromise
- To correct chest deformities resulting from trauma, infection or disease

Pectus Excavatum or Pectus Carinatum Repair is considered cosmetic and therefore **not covered as a benefit exclusion** when performed in the absence of any functional impairment and intended to improve the patient's appearance and self-esteem.

OTHER

Collagen Injections– subcutaneous injection of filling material to restore physiologic function

Supporting Documentation Requested:

- History of present illness and history and physical report demonstrating physical impairment caused by disease, trauma, and/or congenital defect

Collagen Injections may be considered **medically necessary** for the following:

- Documented evidence of significant functional impairment and the expected functional improvement following correction of a physical impairment caused by disease, trauma, and/or congenital defect

Collagen injections are considered cosmetic and therefore **not covered as a benefit exclusion** when performed in the absence of any functional impairment and intended to improve the patient's appearance and self-esteem.

Lipectomy– the excision of a mass of subcutaneous adipose tissue from the body.

Lipectomy is considered cosmetic and therefore **not covered as a benefit exclusion** for the following:

- Low-level laser (cold laser) therapy (e.g. Zerona)
- Excision, excessive skin and subcutaneous tissue for any part of the body
- Suction assisted lipectomy as a primary procedure

NOTE: Suction assisted lipectomy may be eligible with adjunct procedure to an authorized reconstructive procedure. Suction assisted lipectomy may be considered medically necessary when the lipectomy is performed as part of the treatment of lipedema.

Testicular Prosthesis Insertion– insertion of a prosthesis to replace a testicle due to congenital absence or surgical removal.

Supporting Documentation Requested:

- Clinical statement by physician that testicle was either congenitally absent or was surgically removed (due to disease or trauma)
- Date and nature of proposed surgery

Testicular Prosthesis Insertion is considered **medically necessary** for:

- congenital or acquired absence of a testicle

PROCEDURES RELATED TO THE GENITALIA

If services pertain to gender affirming care, refer to the Blue Cross VT Gender Affirming Services Corporate Medical Policy

Procedures including, but not limited to the following:

- Vaginoplasty - reconstruction or rejuvenation of the vagina
- Clitoroplasty– reconstruction or reduction of the clitoris
- Labiaplasty- reconstruction or reduction of the labia
- Vulvectomy– removal of part or all of the vulva
- Vulvoplasty – reconstruction of the vulva
- Phalloplasty – penis lengthening surgery
- Scrotoplasty -surgery to the scrotal sack

The above procedures may be considered **medically necessary** for **ANY** of the following:

- A congenital anomaly is present
- With a medical diagnosis of cancer affecting the area
- The area is affected by severe infection and/or trauma or causing severe functional impairment. The request must include documented evidence of significant functional impairment and the expected functional improvement following correction of physical impairment

The above procedures are considered cosmetic and therefore **not covered as a benefit exclusion** when the above medically necessary criteria are not met and the procedure is performed in order to improve the patient's appearance and self-esteem.

COSMETIC EXCLUSIONS

Cosmetic procedures are a specific exclusion under the subscriber's contract.

Procedures that are considered cosmetic and therefore **non-covered services,** include, but are not limited to:

- Rhytidectomy for the signs of aging;
- Hair transplants;
- Diastasis Recti correction – surgery to correct a separation of the lower abdominal muscles in the midline;
- Ear or Body Piercing – ear and body piercing are considered cosmetic and not medically necessary for all reasons;
- Hair Procedures – Hair transplant for alopecia (including male pattern alopecia) or hair removal (temporary or permanent) for all indications;
- Laser treatment of telangiectasia;
- Excision of excessive skin and subcutaneous tissue, and tightening (plication) of underlying structures (includes abdominoplasty, panniculectomy, correction of diastasis rectus, lipectomy and umbilical transposition) of the chest, abdomen, thigh, leg, hip, buttocks, arm, forearm, hand, neck (submental fat pad) and all other areas not specified;
- Suction-assisted removal of fatty tissue (lipectomy) in the head, neck, trunk, upper extremity or lower extremity;
- Breast lift (mastopexy) except when a necessary component of reconstruction of breasts following breast surgery;

- Surgery to improve the appearance of the ear (otoplasty);
- Repair of brow ptosis, repair of blepharoptosis, correction of lid retraction, reduction of overcorrection of lid ptosis;
- Surgery to improve the appearance of the nose (rhinoplasty);
- Cosmetic procedures and supplies that are not reconstructive

NOTE: This exclusion does not apply to abdominoplasty or panniculectomy when abdominoplasty and/ or panniculectomy is performed in connection with herniorrhaphy (hernia repair).

NOTE: This exclusion does not apply to lipectomy performed as part of the treatment of lipedema.

NOTE: This exclusion does not apply to hair removal as part of approved gender affirming genital procedures.

Reference Resources

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Related Policies

Bioengineered Skin and Soft Tissue Substitutes
Breast Surgery and Breast Prosthesis
Dermatologic Applications of Photodynamic Therapy
Light Therapy for Dermatologic Conditions
Sleep Disorders Diagnosis and Treatment
Temporomandibular Joint (TMJ) Dysfunction
Gender Affirming Services

Document Precedence

Blue Cross and Blue Shield of Vermont (Blue Cross VT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, Blue Cross VT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, Blue Cross VT reserves the right to recoup all non- compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

06/2016	Updated sections. New criteria added. CPT®s embedded within each section. References updated. Breast surgery removed and a new policy for breast surgery has been created.
08/2017	Added coding table to align with codes contained within the medical policy. Added related policies Policy statement remained unchanged.
07/2018	Reformatted sections for ease of reading. Added under section "Torso" medical necessity criteria to allow for certificate language under medical necessity section: Abdominoplasty or panniculectomy when abdominoplasty and/or panniculectomy is performed in connection with herniorrhaphy (hernia repair). Code 15877 changed from benefit exclusion to requiring prior authorization. Codes 17106, 17107 & 17108, changed from requiring prior approval to not requiring prior approval. Code 96999 will suspend for medical review and medical documentation will need to be furnished. Under Section "eyes" added certificate language: Blepharoplasty, repair of brow ptosis, repair of blepharoptosis, correction of lid retraction, reduction of overcorrection of lid ptosis; and" This exclusion does not apply to these procedures if it is due to trauma and meets the definition of reconstructive. Added certificate language for statements around lipectomy.
07/2019	Updated criteria under headers for congenital deformities and blepharoplasty sections. Added codes 96910 & 96913 to require prior approval. Added language around ultraviolet light systems for home use. Updated language in Torso section to correct for BMI.
11/2019	Policy reviewed, update language around blepharoplasty. Added clarifying language in medically necessary section around blepharoplasty. Updated language in panniculectomy torso section of policy. Added codes 15876, 15878 & 15879 from benefit exclusion to Prior Approval Required if not a benefit exclusion in members plan document. Added codes 56620, 56630, 56631, 56632, 56633 as requiring prior approval. Added * to codes 11920, 11921, 11922 to body of policy- no changes to policy statements. Removed codes 15788, 15789, 15792, 15793, 17360 as requiring Prior approval.
06/2020	Reviewed policy updated for minor edits for clarification no changes to policy statements. Removed prior approval to prior approval required if not a benefit exclusion in members plan document for code 15823. Codes 15834, 15835, 15836, 15837, 15838 removed prior approval required to prior approval required if not a benefit exclusion in members plan document.
06/2021	Policy Reviewed. Formatting changes. Removed language addressing treatment of dermatologic conditions; addressed in referenced BCBSVT policies with unchanged Policy Statements. Clarified language around procedures of the genitalia. Updated Reference. Updated related policy section. Added code 21127 requires prior approval.

06/2022	Policy Reviewed. Input received from network provider regarding panniculectomy/abdominoplasty criteria and changes incorporated. The following related BCBSVT Corporate Medical Policies will be archived: Nonpharmacologic Treatment of Rosacea, Laser Treatment of Port Wine Stains. Codes 15780, 15781, 15782, 15783 changed from prior approval required to no prior approval required. Codes 17106, 17107, 17108 changed from refer to corporate medical policy to no prior approval required. Codes 15824, 15825, 15826, 15828, 15829 added to coding table as needing prior approval.
06/2023	Policy Reviewed. Formatting and language edits for clarity and consistency.
02/2024	Policy reviewed. Clarified criteria for panniculectomy, removing BMI of ≤30 as required criteria. Minor formatting changes for clarity. References updated.
01/2025	Coding table updated removed codes 21120, 21121, 21122, 21123, 21125, 21127, 21137, 21138, 21139, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21206, 21208, 21209 from requiring prior approval.
05/2025	Policy reviewed. Clarification of medical necessity criteria for Blepharoplasty, blepharoptosis repair and brow ptosis repair. Clarification of weight loss requirement for panniculectomy. Minor formatting changes for clarity and consistency. References updated.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by Blue Cross VT Medical Directors

Tom Weigel, MD, MBA
Vice President and Chief Medical Officer

Tammaji P. Kulkarni, MD
Senior Medical Director

Attachment I
Coding Table

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	No Prior Approval Required
CPT®	11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)	No Prior Approval Required
CPT®	11300	Shaving of epidermal or dermal lesions, single lesion, trunk, arms or legs; lesion diameter 0.5cm or less	No Prior Approval Required
CPT®	11301	Shaving of epidermal or dermal lesions, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	No Prior Approval Required
CPT®	11302	Shaving of epidermal or dermal lesions, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	No Prior Approval Required
CPT®	11303	Shaving of epidermal or dermal lesions, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm	No Prior Approval Required
CPT®	11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	No Prior Approval Required
CPT®	11306	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	No Prior Approval Required
CPT®	11307	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	No Prior Approval Required

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	11308	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm	No Prior Approval Required
CPT®	11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	No Prior Approval Required
CPT®	11311	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	No Prior Approval Required
CPT®	11312	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	No Prior Approval Required
CPT®	11313	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm	No Prior Approval Required
CPT®	11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	No Prior Approval Required
CPT®	11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm	No Prior Approval Required
CPT®	11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm	No Prior Approval Required

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm	No Prior Approval Required
CPT®	11404	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm	No Prior Approval Required
CPT®	11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm	No Prior Approval Required
CPT®	11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	No Prior Approval Required
CPT®	11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm	No Prior Approval Required
CPT®	11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm	No Prior Approval Required
CPT®	11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm	No Prior Approval Required

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	11424	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm	No Prior Approval Required
CPT®	11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm	No Prior Approval Required
CPT®	11440	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less	No Prior Approval Required
CPT®	11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm	No Prior Approval Required
CPT®	11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm	No Prior Approval Required
CPT®	11443	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm	No Prior Approval Required
CPT®	11444	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm	No Prior Approval Required

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	11446	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm	No Prior Approval Required
CPT®	11920*	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	*Prior Approval Required Except for patients with a diagnosis of breast cancer where prior approval is not required for certain reconstructive procedures
CPT®	11921*	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	*Prior Approval Required Except for patients with a diagnosis of breast cancer where prior approval is not required for certain reconstructive procedures
CPT®	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	*Prior Approval Required Except for patients with a diagnosis of breast cancer where prior approval is not required for certain reconstructive procedures
CPT®	11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	Prior Approval Required
CPT®	11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	Prior Approval Required
CPT®	11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	Prior Approval Required
CPT®	11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	Prior Approval Required

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	Prior Approval Required
CPT®	15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	No Prior Approval Required
CPT®	15781	Dermabrasion; segmental, face	No Prior Approval Required
CPT®	15782	Dermabrasion; regional, other than face	No Prior Approval Required
CPT®	15783	Dermabrasion; superficial, any site (eg, tattoo removal)	No Prior Approval Required
CPT®	15788	Chemical peel, facial; epidermal	No Prior Approval Required
CPT®	15789	Chemical peel, facial; dermal	No Prior Approval Required
CPT®	15792	Chemical peel, nonfacial; epidermal	No Prior Approval Required
CPT®	15793	Chemical peel, nonfacial; dermal	No Prior Approval Required
CPT®	15820	Blepharoplasty, lower eyelid;	Prior Approval Required
CPT®	15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	Prior Approval Required
CPT®	15822	Blepharoplasty, upper eyelid	Prior Approval Required
CPT®	15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	Prior Approval Required
CPT®	15824	Rhytidectomy; forehead	Prior Approval Required. May apply to Gender Affirming Services (Trans Services) - Refer to Corporate Medical Policy
CPT®	15825	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	Prior Approval Required. May apply to Gender Affirming Services (Trans Services) - Refer to Corporate Medical Policy
CPT®	15826	Rhytidectomy; glabellar frown lines	Prior Approval Required. May apply to Gender Affirming Services (Trans Services) - Refer to Corporate Medical Policy

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	15828	Rhytidectomy; cheek, chin, and neck	Prior Approval Required. May apply to Gender Affirming Services (Trans Services) - Refer to Corporate Medical Policy
CPT®	15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	Prior Approval Required. May apply to Gender Affirming Services (Trans Services) - Refer to Corporate Medical Policy
CPT®	15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	Prior Approval Required if not a benefit exclusion in members plan document.
CPT®	15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	Prior Approval Required if not a benefit exclusion in members plan document.
CPT®	15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	Prior Approval Required if not a benefit exclusion in members plan document.
CPT®	15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	Prior Approval Required if Not a Benefit Exclusion in Members Plan Document
CPT®	15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	Prior Approval Required if Not a Benefit Exclusion in Members Plan Document
CPT®	15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	Prior Approval Required if Not a Benefit Exclusion in Members Plan Document
CPT®	15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	Prior Approval Required if Not a Benefit Exclusion in Members Plan Document
CPT®	15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	Prior Approval Required if Not a Benefit Exclusion in Members Plan Document
CPT®	15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	Prior Approval Required if Not a Benefit Exclusion in Members Plan Document

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	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)	Prior Approval Required if Not a Benefit Exclusion in Members Plan Document
CPT®	15876	Suction assisted lipectomy; head and neck	Prior Approval Required if Not a Benefit Exclusion in Members Plan Document
CPT®	15877	Suction assisted lipectomy; trunk	Prior Approval Required
CPT®	15878	Suction assisted lipectomy; upper extremity	Prior Approval Required if Not a Benefit Exclusion in Members Plan Document
CPT®	15879	Suction assisted lipectomy; lower extremity	Prior Approval Required if Not a Benefit Exclusion in Members Plan Document
CPT®	17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratosis); first lesion	No Prior Approval Required
CPT®	17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratosis); second through 14 lesions, each (List separately in addition to code for first lesion)	No Prior Approval Required
CPT®	17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical	No Prior Approval Required
CPT®	17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	No Prior Approval Required

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	No Prior Approval Required
CPT®	17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	No Prior Approval Required
CPT®	17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical	No Prior Approval Required
CPT®	17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions	No Prior Approval Required
CPT®	17340	Cryotherapy (CO_2 slush, liquid N_2) for acne	Prior Approval Required
CPT®	17360	Chemical exfoliation for acne (eg, acne paste, acid)	No Prior Approval Required
CPT®	21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	No Prior Approval Required
CPT®	21121	Genioplasty; sliding osteotomy, single piece	No Prior Approval Required
CPT®	21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	No Prior Approval Required
CPT®	21123	Genioplasty; sliding augmentation with interpositional bone grafts (including obtaining autografts)	No Prior Approval Required
CPT®	21125	Augmentation, mandibular body or angle; prosthetic material	No Prior Approval Required
CPT®	21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	No Prior Approval Required
CPT®	21137	Reduction forehead; contouring only	No Prior Approval Required

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)	No Prior Approval Required
CPT®	21139	Reduction forehead; contouring and setback of anterior frontal sinus wall	No Prior Approval Required
CPT®	21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft	No Prior Approval Required
CPT®	21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft	No Prior Approval Required
CPT®	21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	No Prior Approval Required
CPT®	21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	No Prior Approval Required
CPT®	21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts (eg, ungrafted unilateral alveolar cleft)	No Prior Approval Required
CPT®	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)	No Prior Approval Required
CPT®	21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	No Prior Approval Required

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	No Prior Approval Required
CPT®	21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	No Prior Approval Required
CPT®	21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I	No Prior Approval Required
CPT®	21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I	No Prior Approval Required
CPT®	21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	No Prior Approval Required
CPT®	21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	No Prior Approval Required
CPT®	21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	No Prior Approval Required
CPT®	21209	Osteoplasty, facial bones; reduction	No Prior Approval Required
CPT®	21270	Malar augmentation, prosthetic material	Prior Approval Required
CPT®	21282	Lateral canthopexy	Prior Approval Required
CPT®	21740	Reconstructive repair of pectus excavatum or carinatum; open	Prior Approval Required

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy	Prior Approval Required
CPT®	21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy	Prior Approval Required
CPT®	30117	Excision or destruction (eg, laser), intranasal lesion; internal approach	No Prior Approval Required
CPT®	30118	Excision or destruction (eg, laser), intranasal lesion; external approach (lateral rhinotomy)	No Prior Approval Required
CPT®	30120	Excision or surgical planning of skin of nose for rhinophyma	Prior Approval Required
CPT®	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	Prior Approval Required
CPT®	30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	Prior Approval Required
CPT®	30420	Rhinoplasty, primary; including major septal repair	Prior Approval Required
CPT®	30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	Prior Approval Required
CPT®	30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	Prior Approval Required
CPT®	30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	Prior Approval Required
CPT®	30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	Prior Approval Required

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies	Prior Approval Required
CPT®	30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	No Prior Approval Required
CPT®	30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)	No Prior Approval Required
CPT®	30630	Repair nasal septal perforations	Prior Approval Required
CPT®	54660	Insertion of testicular prosthesis (separate procedure)	Prior Approval Required – Also may apply to transgender service – Refer to Corporate Medical Policy Transgender Services
CPT®	55175	Scrotoplasty; simple	Prior Approval Required- Also may apply to transgender service – Refer to Corporate Medical Policy
CPT®	55180	Scrotoplasty; complicated	Prior Approval Required Also may apply to transgender service – Refer to Corporate Medical Policy
CPT®	56620	Vulvectomy simple; partial	Prior Approval Required
CPT®	56625	Vulvectomy simple; complete	Prior Approval Required Also may apply to transgender service – Refer to Corporate Medical Policy
CPT®	56630	Vulvectomy, radical, partial;	Prior Approval Required
CPT®	56631	Vulvectomy, radical, partial; with unilateral inguinofemoral lymphadenectomy	Prior Approval Required
CPT®	56632	Vulvectomy, radical, partial; with bilateral inguinofemoral lymphadenectomy	Prior Approval Required
CPT®	56633	Vulvectomy, radical, complete;	Prior Approval Required

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	56805	Clitoroplasty for intersex state	Prior Approval Required Also may apply to transgender service – Refer to Corporate Medical Policy
CPT®	57335	Vaginoplasty for intersex state	Prior Approval Required Also may apply to transgender service – Refer to Corporate Medical Policy
CPT®	67900	Repair for brow ptosis (supraciliary, mid-forehead or coronal approach)	Prior Approval Required
CPT®	67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material	Prior Approval Required
CPT®	67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	Prior Approval Required
CPT®	67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	Prior Approval Required
CPT®	67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	Prior Approval Required
CPT®	67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	Prior Approval Required
CPT®	67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle- levator resection (eg, Fasanella- Servat type)	Prior Approval Required
CPT®	67909	Reduction of overcorrection of ptosis	Prior Approval Required
CPT®	67911	Correction of lid retraction	Prior Approval Required
CPT®	69300	Otoplasty, protruding ear, with or without size reduction	Prior Approval Required

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	69310	Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection) (separate procedure)	Prior Approval Required
CPT®	69320	Reconstruction external auditory canal for congenital atresia, single stage	Prior Approval Required
CPT®	69399	Unlisted procedure, external ear	Prior Approval Required
CPT®	96567	Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (Eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session	Prior Approval Required- Refer to Corporate Medical Policy Dermatologic Application of Photodynamic Therapy
CPT®	96573	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	Prior Approval Required- Refer to Corporate Medical Policy Dermatologic Application of Photodynamic Therapy
CPT®	96574	Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	Prior Approval Required- Refer to Corporate Medical Policy Dermatologic Application of Photodynamic Therapy
CPT®	96900	Actinotherapy (ultraviolet light)	Prior Approval Required- Refer to Corporate Medical Policy Light Therapy for Dermatologic Conditions

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	96910	Photochemotherapy; tar and	Prior Approval Required- Refer to Corporate Medical Policy Light Therapy for Dermatologic Conditions
CPT®	96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	Prior Approval Required- Refer to Corporate Medical Policy Light Therapy for Dermatologic Conditions
CPT®	96913	Photochemotherapy (Goeckerman and/or PUVA)	Prior Approval Required- Refer to Corporate Medical Policy Light Therapy for Dermatologic Conditions
CPT®	96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm)	Prior Approval Required- Refer to Corporate Medical Policy Light Therapy for Dermatologic Conditions
CPT®	96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm)	Prior Approval Required- Refer to Corporate Medical Policy Light Therapy for Dermatologic Conditions
CPT®	96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm	Prior Approval Required- Refer to Corporate Medical Policy Light Therapy for Dermatologic Conditions
CPT®	96999	Unlisted special dermatological service or procedure	Will suspend for medical review-need to furnish medical documentation. Refer to Corporate Medical Policy Light Therapy for Dermatologic Conditions
HCPCS	E0691	Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less	Prior Approval not required if purchase price is under dollar threshold-Refer to Corporate Medical Policy Light Therapy for Dermatologic Conditions
HCPCS	E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 foot panel	Prior Approval not required if purchase price is under dollar threshold Refer to Corporate Medical Policy Light Therapy for Dermatologic Conditions

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
HCPCS	E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6foot panel	Prior Approval not required if purchase price is under dollar threshold Refer to Corporate Medical Policy Light Therapy for Dermatologic Conditions
HCPCS	E0694	Ultraviolet multidirectional light therapy system in 6foot cabinet, includes bulbs/lamps, timer and eye protection	Prior Approval not required if purchase price is under dollar threshold Refer to Corporate Medical Policy Light Therapy for Dermatologic Conditions
HCPCS	J7308	Aminolevulinic acid HCL for topical administration, 20%, single unit dosage form (354 mg)	Refer to Corporate Medical Policy Dermatologic Application of Photodynamic Therapy
HCPCS	J7309	Methyl aminolevulinate (MAL) for topical administration, 16.8%, 1 g	Refer to Corporate Medical Policy Dermatologic Application of Photodynamic Therapy
HCPCS	J8999	Prescription drug, oral, chemotherapeutic, NOS	Code Will Suspend for Medical Review Refer to Corporate Medical Policy Light Therapy for Dermatologic Conditions