Cosmetic Services

Description:

Cosmetic procedures are performed primarily to refine or reshape body structures that are not functionally impaired, to improve appearance or self-esteem, or for other psychological, psychiatric, or emotional reasons.

The presence of a functional impairment would render the treatment and/or the procedure medically necessary. (2)

Medical Criteria:

Not Applicable, administrative policy only.

Policy:

Cosmetic surgery or expenses incurred in connection with such surgery are not covered. Services would be considered medically necessary for the treatment of a functional impairment when medical criteria listed in individual policies are met.

Please note that mastectomy-related services, in accordance with the Women's Health and Cancer Rights Act of 1998 and Rhode Island General Law 27-20-29, are covered.

Procedures which are performed to correct a functional impairment resulting from a previous therapeutic process or to correct a documented functional impairment caused by trauma, congenital anomaly, or disease are covered.

Functional indications for surgical correction do not include psychological, psychiatric or emotional reasons.

We DO cover some surgical procedures that may have cosmetic indications when used to treat functional impairments and when medically necessary. Refer to the specific member agreement (all Commercial plans, BlueCHIP for Medicare, and RIte Care agreements) for coverage details, and see the appropriate medical policy for the requirements of each service/procedure.

- Abdominal wall surgery including Panniculectomy;
- Blepharoplasty and Ptosis Repair;
- Gastric Bypass or Gastric Banding;
- Nasal Reconstruction and Septorhinoplasty;
- Orthognathic surgery including Mandibular and Maxillary Osteotomy;
- Reduction Mammaplasty;
- Removal of Breast Implants;
- Removal/Treatment of Proliferative Vascular Lesions and Hemangiomas;
- Removal/Treatment of Symptomatic Benign Skin Lesions; or
- Treatment of Varicose Veins.

The following procedures are Contract Exclusions. They are always considered COSMETIC and are EXCLUDED from coverage for all members under the specific member certificate/subscriber agreement regardless of the stated reason for the service. Medical necessity review will not be undertaken. If the requested service requested is not specifically listed as a Contract Exclusion in the member certificate/subscriber agreement, then a prospective medical necessity review is required. (BlueCHIP for Medicare and RIte Care members do not have Contract Exclusion language in their member certificate/subscriber agreements.)
- Cervicoplasty;
- Chemical exfoliations, peels, abrasions (or dermabrasions or planing for acne, scarring, wrinkling, sun damage or other benign conditions);
- Correction of variations in normal anatomy including augmentation mammoplasty and correction of congenital breast asymmetry;
- Dermabrasion;
- Ear Piercing and/or repair of a torn earlobe;
- Excision of Excess Skin or Subcutaneous Tissue (except Panniculectomy as listed above);
- Genioplasty;
- Hair Transplants;
- Hair Removal (including electrolysis epilation);
- Surgery for Gynecomastia, including but not limited to mastectomy and reduction mammoplasty;
- Osteoplasty: Facial Bone Reduction;
- Otoplasty;
- Procedures to correct visual acuity including, but not limited to, cornea surgery or lens implants;
- Removal of Asymptomatic Benign Skin Lesions;
- Repeated cauterizations or electrofulguration methods used to remove growths on the skin;
- Rhinoplasty;
- Rhytidectomy;
- Scar Revision, regardless of symptoms;
- Sclerotherapy for Spider Veins;
- Subcutaneous Injection of Filling Material;
- Suction assisted Lipectomy;
or
- Tattooing or Tattoo Removal.

Drugs, biological products, hospital charges, pathology, radiology fees, and charges for surgeons, assistant surgeons, attending physicians, and any other incidental services which are related to cosmetic surgery are NOT covered.(1)

Coverage:

Cosmetic procedures are NOT covered. Procedures with a documented functional impairment MAY be covered if they meet the medical necessity criteria outlined in the individual medical policies.

We MAY NOT cover services that are otherwise considered covered when performed with a non-covered service. A separate surgical service performed at the same time as a non-covered service is non-covered for most members (other than BlueCHiP for Medicare and Rite Care). BCBSRI may elect to cover a service that is non-covered solely because it is performed at the same time as a covered service. Additionally, services incidental to the covered surgery (e.g., anesthesia, facility fees) may also be covered in whole or in part. BCBSRI, at its sole discretion, may approve payment for such services. A prospective medical necessity review must be obtained for determination of coverage/reimbursement of these services.

If the service requested is not specifically listed as a Contract Exclusion in the member certificate/subscriber agreement, then a prospective medical necessity review is required. (BlueCHiP for Medicare members do not have Contract Exclusion language in their member certificate/subscriber agreement.)

Benefits may vary between groups/contracts. Please refer to the appropriate member certificate/subscriber agreement/Rite Care contract for applicable surgery coverage/benefits.

Coding:

Please refer to individual medical policies for coding information.

Related Topics:

- Panniculectomy and Abdominoplasty
- Blepharoplasty
- Surgery for Morbid Obesity
- Rhinoplasty and Nasal Reconstruction
- Reduction Mammaplasty
Breast Implant Removal
Laser Treatment of Proliferative Vascular Lesions
Benign Skin Lesion Removal
Varicose Vein Treatment

References:

1. HMC2C Subscriber Agreement: 2007
2. BCBSA: 10.01.09 Reconstructive/Cosmetic Services, extracted from Web: 2-21-07
3. CMS: 120-Cosmetic Surgery (Rev. 1,10-01-03) A3-3160, HO-260.11, B3-2329) extracted from web: 2-21-07

Published:

Policy Update, June 2007

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgement in the treatment of your patients. Benefits and eligibility are determined by the member’s subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions.

This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice.

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