Cosmetic surgery / treatments

These services may or may not be covered by all HealthPartners plans. Please see your plan documents for your own coverage information. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage.

Administrative Process

All requests for coverage of cosmetic surgery/treatment require prior authorization.

Submission of GA modifier waiver is required when requesting services which are always considered a cosmetic service and therefore never covered. (See Coverage section and list of non-covered indications below).

Coverage

Services that are performed to enhance or change the appearance and are not necessary to preserve the health of an individual are always considered to be cosmetic and are not eligible for coverage. This policy is meant to supplement a member’s contracted benefit plan. In the event of a conflict, a member’s benefit plan document always supersedes the information in this coverage policy. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. The provider and facility will be liable for payment unless:

1. The provider notifies the member that a specific service has been determined by HealthPartners to be cosmetic and
2. The member signs a waiver agreeing to pay for the specific non-covered service being rendered and
3. The claim has been billed with a GA modifier indicating such. If the member has signed a waiver agreeing to pay for the specific service then the member will be liable for payment.

Indications that may be covered

The following are examples of procedures or treatments which, depending upon the situation, may be considered cosmetic or medically necessary. For this reason, HealthPartners has developed specific coverage policies to address them. Generally, these procedures require prior authorization. Please refer to the following individual policies for coverage criteria and documentation requirements:

• Blepharoplasty/ Brow Lift/Ptosis Repair
• Breast Surgery (Augmentation/Implant Removal/Lift)
• Breast Reduction Surgery (Reduction Mammoplasty)
• Gynecomastia Surgery for Males
• Hemangioma Treatment
• Hyperhidrosis Treatment (with Thoracic Sympathectomy)
• Laser Treatment for Skin Conditions
• Orthognathic Surgery
• Panniculectomy
• Radiofrequency ablation applications
• Rhinoplasty - plastic surgery to alter nasal appearance
• Scar Revision/Keloids
• Sclerotherapy for varicose veins
• Weight Loss Surgery

Indications that are not covered

Contractual benefits prohibit the coverage of cosmetic services, including those listed below. Please note that while this portion of the policy addresses many common procedures, it does not address all procedures that might be considered to be cosmetic. Per this member contract, the HealthPartners Medical Policy Department, in collaboration with HealthPartners Medical Directors, reserves the right to review and deny coverage for other procedures that are deemed cosmetic.

1. Abdominoplasty or tummy tuck (See Panniculectomy coverage policy)
2. Any skin lesion treated or removed for solely cosmetic purposes
3. Dermabrasion treatment (except for pre-cancerous and cancerous conditions)
4. Diastasis Recti repair (See Panniculectomy coverage policy)
Earlobe repair, except in the event of acute, traumatic injury.

Electrolysis or laser hair removal (including treatment of pseudofolliculitis barbae).

Face lifts (rhytidectomy) or other related procedures to remove wrinkles or diminish the aging process.

Fat grafts to any area unless performed as an integral part of another covered procedure.

Hair transplants or repair of any congenital or acquired hair loss.

Injections of Botox (botulinum toxin) to treat wrinkles.

Injections of dermal fillers to improve the skin's contour or treat wrinkles, scars, or lipoatrophy.

Examples include but are not limited to Artefill, Bellafill, Belotero, Captique, Cosmoderm, Elevess, Evolence, Fibrel, Hyalform (Hylan B Gel), Juvederm, Prevelle Silk, Radiesse, Restylane, Sculptra, Zyderm and Zyplast.

Laser facial resurfacing for treatment of acne scarring.

Laser treatment of rosacea, a common skin condition in which certain facial blood vessels enlarge, giving the cheeks and nose a flushed appearance.

Laser treatment for removal of spider veins (telangiectasia or spider angioma).

Mesotherapy (injection of pharmaceutical and homeopathic medications, plant extracts, vitamins and other ingredients into the tissue beneath the skin to sculpt body contours by lysing subcutaneous fat).

Otoplasty surgery for protruding ears.

Removal of excessive skin, thigh (thighplasty), leg, hip, buttock, arm(brachioplasty), forearm, hand, or neck (cervicoplasty).

Tattoo removal.

Testicular implants for congenitally absent testes.

Vaginal rejuvenation procedures (including clitoral reduction, designer laser vaginoplasty, G-spot amplification, pubic liposuction or lift, reduction of labia minora, labia majora surgery or re-shaping, labiaplasty, or vaginal tightening).

**Definitions**

**Cosmetic** The term given to surgery or treatment which is performed to enhance or change the appearance of an abnormal or normal body part and is not necessary to preserve the health of an individual.

**Codes**

*If available, codes for a procedure, device or diagnosis are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive.*

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11950</td>
<td>Subcutaneous injection of filling material (eg, collagen); 1 cc or less</td>
</tr>
<tr>
<td>11951</td>
<td>Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc</td>
</tr>
<tr>
<td>11952</td>
<td>Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc</td>
</tr>
<tr>
<td>11954</td>
<td>Subcutaneous injection of filling material (eg, collagen); over 10.0 cc</td>
</tr>
<tr>
<td>15775</td>
<td>Punch graft for hair transplant; 1 to 15 punch grafts</td>
</tr>
<tr>
<td>15776</td>
<td>Punch graft for hair transplant; more than 15 punch grafts</td>
</tr>
<tr>
<td>15780</td>
<td>Dermabrasion; Total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)</td>
</tr>
<tr>
<td>15781</td>
<td>Dermabrasion; segmental, face</td>
</tr>
<tr>
<td>15782</td>
<td>Dermabrasion; regional, other than face</td>
</tr>
<tr>
<td>15783</td>
<td>Dermabrasion; superficial, any site (eg, tattoo removal)</td>
</tr>
<tr>
<td>15788</td>
<td>Chemical peel, facial; epidermal</td>
</tr>
<tr>
<td>15789</td>
<td>Chemical peel, facial; dermal</td>
</tr>
<tr>
<td>15792</td>
<td>Chemical peel, non-facial; epidermal</td>
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<tr>
<td>15793</td>
<td>Chemical peel, non-facial; dermal</td>
</tr>
<tr>
<td>15819</td>
<td>Cervicoplast</td>
</tr>
<tr>
<td>15824</td>
<td>Rhytidectomy; forehead</td>
</tr>
<tr>
<td>15825</td>
<td>Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)</td>
</tr>
<tr>
<td>15826</td>
<td>Rhytidectomy; glabellar frown lines</td>
</tr>
<tr>
<td>15828</td>
<td>Rhytidectomy; cheek, chin, and neck</td>
</tr>
<tr>
<td>15829</td>
<td>Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap</td>
</tr>
<tr>
<td>15830</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lpectomy); abdomen, infra-umbilical panniculectomy</td>
</tr>
<tr>
<td>15832</td>
<td>Excision, excessive skin and subcutaneous tissue (includes lpectomy); thigh</td>
</tr>
</tbody>
</table>
Approved Medical Director Committee 01/01/94; Revised 07/01/99

or for a copy of a Medicare coverage policy, contact Member Services at

Medicare Products if Medicare requires different coverage. For more information regarding Medicare coverage criteria
documents, your plan documents will be used to determine your coverage. These coverage criteria may not apply to
has limits or will not cover some items. If there is a difference between this general information and your plan

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Approved Medical Director Committee 01/01/94; Revised 07/01/99, 4/21/10, 7/1/10, 8/24/11, 8/13/13, 8/2016, 7/2017; Annual Review 6/1/06, 8/1/07, 8/1/08, 9/9/09, 6/9/10, 7/1/10, 7/2011, 7/2012, 6/2013, 8/2013, 8/2014, 8/2015, 8/2016, 8/2017

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**Products**

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