MEDICAL POLICY

Medical Policy Title	**Cosmetic and Reconstructive Procedures**
Policy Number	**7.01.11**
Current Effective Date	**September 18, 2025**
Next Review Date	**September 2026**

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

This policy does not address criteria related to gender affirming surgeries/procedures. Refer to the Related Policies section below for policy reference.

Reconstructive Procedures

I. A procedure is considered reconstructive and **medically appropriate** when **ALL** of the following are met:

A. **ONE** (1) of the following definitions of functional deficit is documented:

1. Pain or other physical deficit that interferes with activities of daily living; **or**
2. Impaired physical activity;

B. **ONE** (1) of the following definitions of reconstruction is documented:

1. The procedure is performed to correct structures of the body affected by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease that have resulted in the functional deficit;
2. Reconstructive procedures incidental to or following surgery to treat an accidental injury, infection, or other disease of the part of the body involved, that correct the functional deficit; **or**
3. The procedure is intended to correct a congenital disease or anomaly of a child that has resulted in the functional deficit; **and**

C. Indication specific criteria are met below:

1. Acne procedures (10040, 11900, 11901)

a. Intralesional injection of painful acne cysts

b. Surgical drainage of painful acne lesions (acne surgery)

For comedone extraction or chemical exfoliation, refer to Policy Statement II

For cryotherapy (e.g., carbon dioxide [CO2] slush, liquid nitrogen), refer to Policy Statement III

Related CMP #8.01.21 Light and Laser Therapies for Dermatologic Conditions

2. Actinic keratoses
    a. The use of surgical or medical treatment methods, including, but not limited to cryosurgery, curettage, and excision

    Related CMP #8.01.21 Light and Laser Therapies for Dermatologic Conditions

3. Benign skin lesions, including skin tag removal (11200-11201, 11300-11313, 1140-11474, 17110-17111):
    a. Treatment is required due to bleeding, pain, recent changes in physical appearance (e.g., color, size), obstruction of an orifice, clinically restricts eye function, or exposure to frequent irritation.

    For any other indication, refer to Policy Statement II.

4. Breast procedures: augmentation with implant (19325), correction of asymmetry, grafting of autologous fat or tissue (15769, 15771-15772), mastopexy/breast lift (19316), nipple tattooing (11920, 11921, 11922) when **EITHER** of the following criteria are met:
    a. A significant functional deficit is documented; **or**
    b. When performed during or after surgical mastectomy, including partial mastectomy (e.g., lumpectomy, segmentectomy, quadrantectomy) for benign or malignant disease as required under applicable law.

    For any other indication, refer to Policy Statement II.

    Related CMP #10.01.01 Breast Reconstruction Surgery and Prophylactic Breast Cancer Risk-Reducing Mastectomy

    Related CMP #7.01.39 Reduction Mammaplasty (Mammoplasty) for female breast reduction.

    Related criteria InterQual, Reduction Mammaplasty, Male for male mastectomy for gynecomastia.

5. Congenital chest wall deformity surgical correction (21740, 21742, 21743):
    a. Pectus excavatum:
        i. Haller index is 3.25 or greater;
        ii. **ONE** (1) of the following criteria documenting functional impairment are met:
            a) Cardiac impairment including but not limited to conduction abnormalities, cardiac displacement, reduced cardiac output;
            b) Pulmonary impairment as evidenced by paradoxical respirations or pulmonary function tests (PFTs) demonstrating restrictive or obstructive lung capacity; **or**
            c) Exercise intolerance as demonstrated by cardiopulmonary exercise testing

(CPET) results that are below the predicted values; (See Policy Guidelines).

b. Pectus carinatum or Poland syndrome:

i. **ONE** (1) of the following criteria documenting functional impairment are met:

a) Cardiac impairment including but not limited to conduction abnormalities, cardiac displacement, reduced cardiac output;

b) Pulmonary impairment as evidenced by paradoxical respirations or pulmonary function tests (PFTs) demonstrating restrictive or obstructive lung capacity; **or**

c) Exercise intolerance as demonstrated by cardiopulmonary exercise testing (CPET) results that are below the predicted values; (See Policy Guidelines).

6. Dermabrasion (15780, 15781, 15782, 15783)

a. When the documented functional deficit results from a traumatic injury, previous surgery, or burn.

For any other indication, refer to Policy Statement II.

7. Ear or body piercing repair (12001, 12011, 12051)

a. Repair, immediately post-injury, of traumatic laceration

For any other indication, refer to Policy Statement II.

8. Hemangioma treatment (17106, 17107, 17108)

a. Treatment of hemangioma(s), including laser therapy, when a functional deficit (e.g., bleeding, ulceration, affecting a vital structure [e.g., nose, eyes, lips]) is documented.

9. Hyperhidrosis

a. Surgical treatments including endoscopic transthoracic sympathicotomy/ sympathectomy (ETS), sympathectomy (radial artery, ulnar artery, superficial palmar arch), video assisted thoracic sympathectomy (VATS), and surgical excision of axillary sweat glands (32664, 64821, 64822, 64823, 97033) when **BOTH** of the following criteria are met:

i. Documentation of **ONE** of the following:

a) a medical complication such as skin breakdown with secondary infections (e.g., folliculitis or cellulitis requiring treatment with systemic antibiotics, or fissuring or cracking); **or**

b) documented significant biopsychosocial functional impairments (e.g., agoraphobia requiring mental health intervention); **and**

ii. Documentation supporting inability to tolerate or failure of **ALL** the following conservative therapies:

a) Topical aluminum chloride or other extra-strength antiperspirants are ineffective or result in a severe rash;

b) Patient is unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating; **and**

c) For treatment of primary focal axillary hyperhidrosis only: Patient has failed to adequately respond to treatment with botulinum toxin A (Botox A).

For other treatments, refer to Policy Statement III.

10. Hypertrophic scar revision (e.g., burn laceration, surgical incision, and keloid) (0479T, 0480T, 11400 - 11446, 11900, 11901, 17110, 17111, 17999) when **ALL** of the following criteria are met:
    a. The treatment is expected to improve the significant functional deficit (e.g., contracture, limited range of motion; **and**
    b. Treatment includes **ONE** (1) of the following:
        i. intralesional injection of corticosteroid or 5-fluorouracil;
        ii. fractional ablative laser; **or**
        iii. surgical excision.

    This policy does not address adjunct radiation treatment for keloids.

    Related CMP #10.01.01 Breast Reconstruction Surgery and Prophylactic Breast Cancer Risk-Reducing Mastectomy
11. Otoplasty / Pinnaplasty (69300)
    a. For the treatment of congenital protruding or prominent ears when **BOTH** of the following are met:
        i. a functional deficit is documented; **and**
        ii. when the distance from helical rim to mastoid is greater than or equal to 2.1 centimeters (cm) (normal distance is 1.5-2.0 cm).
12. Rhytidectomy (face lift) (15824 - 15829)
    a. The functional deficit is a result of facial nerve palsy

    For any other indication, including glabella (frown line correction), refer to Policy Statement II.
13. Rosacea, including erythematotelangiectatic rosacea (visible dilated blood vessels [telangiectasia]) (17106-17108)
    a. When **ONE** of the following treatment methods is used to treat the functional deficit (e.g., bleeding, ulceration, affecting a vital structure [e.g., nose, eyes, lips]):
        i. Photoablation

ii. Laser treatment; **or**

iii. Ultraviolet light therapy.

14. Vulvectomy (56620, 56625)

a. Vulvectomy as part of surgery to treat cancer or pre-cancerous lesions (dysplasia) is considered **medically appropriate**.

For vaginal rejuvenation procedures, refer to Policy Statement II.

Cosmetic Procedures

II. Cosmetic procedures are performed to reshape structures of the body to improve a patient's appearance or self-esteem in the absence of a functional deficit.

Unless the criteria outlined in Policy Statement I are met, the following non-inclusive list of procedures are typically considered cosmetic and **not medically necessary** for **ALL** indications. A medical exception may be considered when clinical records document a significant functional deficit that cannot be adequately addressed through conservative treatments.

A. Benign skin lesions (11300-11313; 11400-11471; 17110-17111);

B. Body sculpting, non-surgical (e.g., cryolipolysis [also known as fat freezing; e.g., CoolSculpting], deoxycholic acid injection [e.g., Kybella, CPT J0591]);

C. Breast augmentation with implants (19325);

D. Breast lift (mastopexy) (19316);

E. Chemical exfoliation or peel (15788 - 15793, 17360);

F. Comedone extraction, including when combined with light/laser technology (e.g., TheraClearX);

G. Dermabrasion (15780 - 15783);

H. Grafting of autologous fat or tissue (15769 - 15772);

I. Hairplasty (hair transplant) (15775, 15776);

J. Hair removal, including for treatment of hirsutism or hypertrichosis (17380, 17999);

K. Ear or body piercing (69090);

L. Ear lobe or body piercing repair (12001, 12011, 12051);

M. Rhytidectomy, including for glabella (frown line) correction (15824 - 15829);

N. Tattooing (CPT 11920, 11921, 11922);

O. Tattoo removal (CPT 11920, 11921, 11922, 15783);

P. Vaginal rejuvenation (e.g., labiaplasty, vulvectomy) (56620, 56625);

Q. Voice lifting procedures.

III. The following procedures are considered **investigational**:

A. Cryotherapy (carbon dioxide [CO2] slush, liquid nitrogen) in the treatment of acne (17340);

B. The following treatments for hyperhidrosis: acupuncture, axillary liposuction, homeopathy, hypnosis, massage, and phytotherapy (use of extracts from natural origin as medicines);

C. Autologous epidermal cell (cultured and noncultured melanocytic) transplantation for skin repigmentation as a treatment for vitiligo (15011 – 15018, C1832).

Related CMP #8.01.21 Light and Laser Therapies for Dermatologic Conditions

RELATED POLICIES

Corporate Medical Policy

For criteria specifically related to gender affirming surgeries/procedures, refer to either:

- 7.01.84 Gender Affirming Surgery and Treatments for Commercial and Medicare Advantage Members, or
- 7.01.105 Gender Reassignment/Gender Affirming Surgery and Treatments for Medicaid and HARP Members

7.01.39 Reduction Mammaplasty

7.01.47 Varicose Vein Treatments

7.01.53 Abdominoplasty and Panniculectomy

7.01.55 Blepharoplasty with or without Levator Muscle Advancement

7.01.119 Injectable Fillers for Dermal and Laryngeal Conditions

8.01.21 Light and Laser Therapies for Dermatologic Conditions

10.01.01 Breast Reconstruction Surgery and Prophylactic Breast Cancer Risk-Reducing Mastectomy

11.01.03 Experimental or Investigational Services

Pharmacy Management Drug Policy

-09 Clinical Review Prior Authorization (CRPA) Rx

-72 Step Therapy

POLICY GUIDELINE(S)

I. Requests for procedures or services will be considered in accordance with State and Federal Law.

II. When procedures are intended to improve impaired function/functional deficit, coverage will be considered based on adequate documentation submitted for clinical review. Documentation must be provided upon request and prior to performing the procedure. This may include objective documentation of any impairment(s), study/test results, description and duration of conservative treatments, photographs, copies of consultations, and any other pertinent information.

III. If a medical condition results from a cosmetic procedure, medically necessary services required to treat the medical condition will be eligible for coverage. Common, anticipated, side effects (e.g., nausea and vomiting that results in a prolonged hospital stay) are considered part of the cosmetic procedure and are ineligible for coverage.

IV. Normal cardiopulmonary exercise testing (CPET) results: peak oxygen content (PVO_2) >84% predicted; ventilatory anaerobic threshold (VAT) >40% PVO2 (40–80%); maximum heart rate (HRmax) >90% age predicted; heart rate reserve (HRR) <15 beats per minute; blood pressure (BP) <220/90; O2 pulse (VO2/HR) >80%; Ventilatory reserve (VR) MVV2VEmax >11 liters or VEmax/MVV x 100 <85%, respiratory rate (RR) <60 breaths per minute; minute ventilation/carbon dioxide output ratio (VE/VCO2) at VAT <34 (Albouaini 2007).

DESCRIPTION

Acne vulgaris is a chronic, inflammatory skin disease that primarily presents with open or closed comedones, papules, pustules, or nodules on the face or trunk and may result in pain, erythema, hyperpigmentation, or scars. Acne inversa (hidradenitis suppurativa) is a chronic follicular occlusive disease primarily affecting the axilla, waist, groin, perianal, perineal, and inframammary areas.

Actinic keratosis (AKs), also known as solar keratoses, are common, sun-induced skin lesions that are confined to the epidermis and have the potential to become a skin cancer. Various options exist for treating AKs, including cryosurgery with liquid nitrogen, topical drug therapy, and curettage. Less commonly performed treatments for AK include dermabrasion, excision, chemical peels, laser therapy, and photodynamic therapy.

Hyperhidrosis is defined as excessive sweating beyond a level required to maintain normal body temperature, in response to heat exposure or exercise. It can be classified as primary or secondary. Primary focal hyperhidrosis is idiopathic, typically involving the hands (palmar), feet (plantar), or axillae (underarms). Secondary hyperhidrosis can result from a variety of drugs (e.g., tricyclic antidepressants, selective serotonin reuptake inhibitors) or underlying diseases/conditions (e.g., febrile diseases, diabetes, menopause). Secondary hyperhidrosis is usually generalized or craniofacial sweating. Secondary gustatory hyperhidrosis is excessive sweating on ingesting highly spiced foods. Frey syndrome is an uncommon type of secondary gustatory hyperhidrosis that arises from injury to or surgery near the parotid gland resulting in damage to the secretory parasympathetic fibers of the facial nerve. A variety of therapies have been investigated for primary hyperhidrosis, including topical therapy with aluminum chloride, topical anticholinergic medications, oral anticholinergic medications, iontophoresis, intradermal injections of botulinum toxin, endoscopic transthoracic sympathectomy, and surgical excision of axillary sweat glands. Treatment of secondary hyperhidrosis focuses on treatment of the underlying cause, such as discontinuing certain drugs or hormone replacement therapy as a treatment for menopausal symptoms.

Keloids and hypertrophic scars are fibroproliferative disorders that result from aberrant wound healing in predisposed individuals following trauma, inflammation, surgery, or burns. While hypertrophic scars do not exceed the margins of the original wound, keloids are characterized by continuous growth and invasion into the adjacent, healthy skin beyond the original wound boundary. Keloids are often associated with pain and itch, can be disfiguring, and impair function and quality of

life. Keloids also have a marked tendency to recur when surgically excised. Although hypertrophic scars and, especially, keloids are widely perceived as difficult to treat and at high risk of recurrence, advances in the understanding of the pathophysiology of abnormal scars has led to improved therapeutic approaches and outcomes (Ogawa 2024). Numerous treatment options exist (e.g., intra-lesional corticosteroid injections, pressure therapy, cryotherapy, surgical excision followed by immediate adjunctive postoperative low dose radiation therapy. Radiation is typically indicated for recurrent keloids or those at high risk of recurrence.

Otoplasty is a surgical procedure performed to correct protruding or prominent ears, a congenital deformity that can result in social and psychological problems. Assessment of the ear includes measurement of the distance from the scalp to the helix at three points. In the normal ear, the upper third of the helix is 10-12 millimeters (mm) from the skull, the middle third is 16-18 mm from the skull, and the lobule is 20-22 mm from the mastoid and should not project beyond the upper two thirds of the ear. The ideal age for otoplasty surgery is 4 or 5, which is when the ears have become firmer and mostly stopped growing.

Pectus defects are a group of congenital conditions where the sternum is depressed back towards the spine (excavatum), protrudes forwards (carinatum) or more rarely is a mixture of both. For the majority of patients, it is well tolerated, but some patients are affected psychologically, physiologically, or both. A small number of patients have more extreme depression of their sternum that impedes their physiological reserve, which can occur when engaging in strenuous exercise (e.g., running) but can also limit moderate activity such as walking and climbing stairs. The effects can be so extreme that symptoms occur at rest or cause life-threatening compression of the major blood vessels and organs (Dunning 2024). When investigating a patient with pectus excavatum with suspected cardiac compression, cross-sectional imaging of the thorax to determine the Haller index. A Haller index of 3.25 is consistently used to determine the severe category.

Poland syndrome is a rare congenital condition that is classically characterized by absence (aplasia) of chest wall muscles on one side of the body (unilateral) and abnormally short, webbed fingers (symbrachydactyly) of the hand on the same side (ipsilateral) (National Organization for Rare Disorders 2015). Affected individuals may have variable associated features, such as underdevelopment or absence of one nipple (including the darkened area around the nipple [areola]) and/or patchy absence of hair under the arm. In females, there may be underdevelopment or absence of one breast and subcutaneous tissues. In some cases, associated skeletal abnormalities may also be present, such as underdevelopment or absence of upper ribs; elevation of the shoulder blade (Sprengel deformity); and/or shortening of the arm, with underdevelopment of the forearm bones (i.e., ulna and radius). Surgical intervention, although rarely necessary, can be indicated for reasons including paradoxical movement of the chest wall, severe rib hypoplasia and aplasia, hypoplasia or aplasia of the female breast, and cosmetic indication for men and women with chest wall asymmetry (Tafti 2023).

Rosacea is characterized by episodic erythema, edema, papules, pustules, and telangiectasia that occur primarily on the face but also present on the scalp, ears, neck, chest, back, and occasionally rosacea may affect the eyes. Rosacea is not life-threatening, but if not treated, it may lead to persistent erythema, telangiectasias, and rhinophyma (hyperplasia and nodular swelling and

congestion of the skin of the nose). While the clinical manifestations of rosacea do not usually impact the physical health status of the patient, psychological consequences from the most visually apparent symptoms (i.e., erythema, papules, pustules, telangiectasias) may impact quality of life. Rhinophyma, an end-stage form of chronic acne, has been associated with obstruction of nasal passages and basal cell carcinoma in rare, severe cases. The probability of developing nasal obstruction or basal or squamous cell carcinoma with rosacea is not sufficient to warrant the preventive removal of rhinophymatous tissue. Treatment may include pharmacologic therapy or nonpharmacologic therapies such as dermabrasion, chemical peels, surgical debulking, and electrosurgery.

Vitiligo is a disease that causes areas of skin to lose color, resulting in spots and patches of lighter skin that can develop anywhere on a person's skin (American Academy of Dermatology 2022). Vitiligo can affect eyes, mucous membranes, hair color, and melanocytes in the inner ear leading to hearing loss. When vitiligo is actively destroying cells that give a person's skin its color, the patches can itch and can be pink or tricolor (causing a zone of tan skin between a person's natural skin color and the white vitiligo). Once vitiligo is no longer active, the patches turn completely white. There is no one best treatment for vitiligo. Personal preference, the type of vitiligo, where it appears on the body, and how it's progressing also play important roles. Treatment options include cover up (makeup or self-tanner), medication (e.g., corticosteroids, tacrolimus ointment, JAK inhibitor), and light therapy. The transplantation of cultured and noncultured melanocytic cells has emerged as one of the most novel treatment alternatives and consists of obtaining melanocytic and keratinocyte cells from a donor site and then transplanting them to the diseased site. This treatment can be performed autologously using different graft harvesting methods, as well as cell preparation (Souroujon 2023).

SUPPORTIVE LITERATURE

Acne Treatment Procedures

Cryotherapy (cryoslush) treatment has insufficient published evidence to determine the safety and efficacy for the treatment of acne. A pilot clinical trial investigated the feasibility and efficacy of precision cryotherapy for acne vulgaris on a small sample of volunteers (n=20) using the TargetCool (RecensMedical Inc.) carbon dioxide-based device (Hong 2024). The authors reported a significant reduction (90.25%) in the acne lesion count by week 4, with clinical improvement indicated by the Investigator Global Assessment (IGA) scale score reduction ($p<0.001$). The erythema index (EI) showed notable improvements at weeks 1, 2, and 4. Study limitations (e.g., small size and short-term follow-up) are noted to impact the generalizability of the results.

Actinic Keratosis (AK)

There is significant evidence from prospective studies and comparative trials to support the use of cryosurgery as a readily available, rapid, and effective lesion-directed treatment for AKs. Clinically, cryosurgery has been reported to cure between 57% and 98.8% of AKs followed up over 3 months to 8.5 years (Eisen 2021).

Steeb et al (2020) conducted a systematic review and meta-analysis assessing the efficacy and safety of chemical peels for the treatment of actinic keratosis. A total of eight (8) trials were included in the systematic review (4 RCTs, 2 non-randomized controlled trials, and 2 single-arm studies). Data

analysis and interpretation of results were challenged by the presence of multiple study designs and the investigation of multiple distinct comparisons. The studies included in the review were at a high risk for selection bias because only one study clearly described the generation of a random sequence and performed allocation concealment. None of the patients in the studies were blinded; blinding of the outcome assessor was described in one study. Additionally, the chosen efficacy outcomes refer to short-term clearance rates but may not reflect long-term results. Overall, the authors concluded that additional high-quality studies and a standardization of peeling protocols were warranted in order to appropriately determine the value of chemical peeling as a treatment for actinic keratoses.

Congenital Chest Wall Deformity Correction

Zens et al (2022) acknowledge that repair of pectus excavatum has cosmetic benefits, but the physiological impacts remain controversial. A single-center analysis was conducted to characterize the relationship between the degree of pectus excavatum and cardiopulmonary dysfunction seen on cardiac magnetic resonance (CMR; n=345) imaging, cardiopulmonary exercise testing (CPET; n=261), and pulmonary function testing (PFT; n=281). The right ventricular ejection fraction (RVEF) was <0.50 in 16% of patients, left ventricular ejection fraction (LVEF) was <0.55 in 22%, RVEF Z-score was <-2 in 32%, and the LVEF Z-score was < -2 in 18%. CPET revealed 33% of patients had reduced aerobic fitness. PFT results were abnormal in 23.1% of patients. Adjusted analyses revealed the Haller index had significant (P<.05) inverse associations with RVEF and LVEF. The authors concluded the severity of pectus excavatum is associated with ventricular systolic dysfunction. Pectus excavatum impacts right and left ventricular systolic function and can also impact exercise tolerance. The Haller index and correction index may be the most useful predictors of impairment.

Rosacea

No randomized controlled trials (RCTs) evaluating dermabrasion, chemical peels, surgical debulking, or electrosurgery for treating rosacea were identified.

Scar Revision, Including Burn and Keloid

Walsh et al (2023) conducted an evidence-based systematic review of recent advances in keloid treatments up to November 2020. The search was limited to prospective studies (n=108) that were peer-reviewed and reported on clinical outcomes of keloid therapies. The authors concluded that current literature supports silicone gel or sheeting with corticosteroid injections as first-line therapy for keloids. Adjuvant intralesional 5-fluorouracil (5-FU), bleomycin, or verapamil can be considered, although mixed results have been reported with each. Laser therapy can be used as independent therapy for keloids or in combination with intralesional corticosteroids or topical steroids with occlusion to improve drug penetration. Excision of keloids with immediate post-excision radiation therapy is an effective option for recalcitrant lesions. There is sparse but emerging evidence on the utilization of photodynamic therapy (PDT) in treating keloids and hypertrophic scars. Extracorporeal shockwave therapy (ESWT) as a monotherapy for keloids showed a reduction in volume, height, and appearance that was not significantly different compared to intralesional triamcinolone. Further long-term studies of the effect of ESWT would be interesting as an additional treatment modality prior to excision. Intralesional cryotherapy is recommended for smaller lesions. Laser-assisted delivery of corticosteroids and combination of different lasers for treatment of keloids are emerging treatments.

Vitiligo – Transplantation

The evidence is insufficient to determine that the procedure results in an improvement in the net health outcome.

Souroujon and colleagues (2023) aimed to address the gap in knowledge and literature on autologous cell transplant as a therapeutic approach for stable segmental vitiligo. Stating that autologous cell transplant has emerged as a promising modality for managing vitiligo, with cultured and non-cultured transplants being considered when determining the patient's treatment approach, the authors conducted a systematic review of the literature to assess the efficacy of the melanocyte and keratinocyte transplantation. Six studies were assessed (2 case reports, 3 pilot studies, 1 case series), for a total of 23 patients. Although the studies were limited by factors such as sample size, lack of data (e.g., age), and use of different technique for cell preparation, the authors concluded that autologous cell transplantation in stable segmental vitiligo holds tremendous promise as a viable alternative. Final recommendation is to further explore and thoroughly investigate the potential of cell transplantation and its associated techniques to establish comprehensive guidelines for standardizing transplantation procedures.

Lou and colleagues (2024) conducted a systematic review and meta-analysis of randomized trials to assess the efficacy and safety of autologous epidermal cell suspensions for re-epithelialization of skin lesions. The primary output measure was the healing time, and the secondary outputs were effective rate, size of donor site for treatment, size of study treatment area, operation time, pain scores, repigmentation, complications, scar scale scores and satisfaction scores. A total of 32 RCTs met inclusion criteria, for a total of 1552 patients grouped into the autologous epidermal cell suspensions group, control group, and within-subject controlled. Of these trials, stable vitiligo was studied in 12 trials (n=417 patients), with a follow-up range of 3- to 24-months. The pooled data from all included studies demonstrated that the treatment group has significantly reduced healing time ($p=0.02$), size of donor site for treatment ($p<0.001$) operation time ($p<0.001$), pain scores ($p=0.0002$), and complications ($p=0.03$). There were no significant differences in the size of study treatment area, depigmentation, scar scale scores and satisfaction scores between the two groups. Identified study limitations include a small number of studies, study bias, and varying methodological quality. Specific to stable vitiligo, the authors concluded that autologous epidermal cell suspensions present a safe and effective treatment and is potentially useful in early-stage interventions. Overall, the authors conclude that this systematic review support the potential role of autologous epidermal cell suspensions as a novel approach to the management of acute or chronic wounds, and vitiligo; however, the authors found that this intervention has minimal impact on size of treatment area, repigmentation, scar scale scores and satisfaction scores.

PROFESSIONAL GUIDELINE(S)

Acne Vulgaris

The American Academy of Dermatology (AAD) issued guidelines for the care management of acne vulgaris with 18 evidenced-based recommendations and five (5) good practice statements (Reynolds 2024). The AAD made a good practice recommendation supporting the use of intralesional corticosteroid injections as an adjuvant therapy treatment option in patients with larger acne papules

or nodules. The AAD found that the available evidence is insufficient to develop a recommendation on the use of acne lesion/comedo extraction, chemical peels (including glycolic acid, trichloroacetic acid, salicylic acid, Jessner's solution, or mandelic acid), or photodynamic therapy with aminolevulinic acid for the treatment of acne.

In 2023 the National Institute for Health and Care Excellence (NICE) published updated guidelines on the management of acne vulgaris and recommends the use of intralesional corticosteroids in treating severe inflammatory cysts.

Actinic Keratosis

The American Academy of Dermatology (AAD) issued guidelines for the care management of actinic keratosis with 18 recommendations based on the best available evidence (Eisen 2021). Strong recommendations are made for using ultraviolet protection, topical imiquimod, topical 5-fluorouracil, and cryosurgery. A conditional recommendation, based on moderate evidence, was made for treatment with cryosurgery over CO2 laser ablation and for treatment with aminolevulinic acid (ALA)-red light photodynamic therapy (PDT) over 35% trichloroacetic acid (TCA) peel.

Hirsutism

In 2018, the Endocrine Society issued clinical practice guidelines for the evaluation and treatment of Hirsutism (Martin et al., 2018). The goal in assessing hirsutism is to determine the specific etiology and to provide a baseline for the patient. There are two main approaches to the management of hirsutism that may be used either individually or in combination: pharmacologic therapies that target androgen production and action, and direct hair removal methods. The Endocrine Society suggests pharmacotherapy as initial therapy. Cosmetic measures to manage hirsutism include methods that remove hair shafts from the skin surface (depilation) and those that extract hairs to above the bulb (epilation). Shaving is a popular depilation method that removes hair down to just below the surface of the skin. Chemical depilatory agents are also commonly used to dissolve the hair. Epilation methods (e.g., plucking or waxing) can cause some discomfort but are relatively safe and inexpensive. These methods do not cause an increase in hair diameter.

Hyperhidrosis

This International Hyperhidrosis Society developed five separate clinical guidelines and algorithms for treatment of hyperhidrosis (generalized as well as focal) to help guide clinicians as they determine the optimal therapeutic course. The general recommendation is to attempt more conservative therapy before resorting to invasive treatment.

The National Institute for Health and Care Excellence (NICE) issued two interventional procedures guidance recommendations for hyperhidrosis. In 2014, endoscopic thoracic sympathectomy (ETS) was recommended for primary hyperhidrosis of the upper limb only for patients suffering from severe and debilitation primary hyperhidrosis that has been refractory to other treatments. In 2017, NICE determined that the evidence on the safety and efficacy of transcutaneous microwave ablation for severe primary axillary hyperhidrosis is inadequate in quantity and quality.

Hypertrophic Scar Revision, Including Burn and Keloid

In 2019, in the absence of guidelines on the use of superficial radiation therapy (SRT) for treatment

of keloids a group of qualified dermatologists issued consensus guidelines with recommendations for treatment based on published evidence (Nestor 2019). The authors reported that an enormous body of literature has demonstrated the effectiveness of SRT as an adjunctive therapy for the treatment of keloid scars that are resistant to other therapies, postsurgical treatment of keloid excision suture lines with several fractions of SRT significantly reduces keloid recurrence rates, and with three (3) post-surgical fractions. Although effective outcomes can be achieved with single doses of SRT, long-term sequelae are improved with three doses.

In 2020, an international consensus recommendation for laser treatment of traumatic scars and contractures was published (Seago 2020). The panel members are unanimous in their view that lasers are a first-line therapy in the management of traumatic scars and contractures. The lasers that target all major chromophores in the skin have demonstrated utility in the management of traumatic scars including hemoglobin (e.g., 595-nm pulsed dye laser [PDL]), pigment (e.g., 532-, 694-, 755-, and 1064-nm lasers), and tissue water (e.g., 1,540- and 1,565-nm non-ablative fractional lasers [NAFL]), 2940- and 10,600-nm ablative fractional lasers (AFL), and full- field ablative lasers. The fractional lasers, especially AFL, have the most potential to treat the entire range of clinical issues as a single modality.

- For larger traumatic injuries such as burns, over 90% of panelists would begin laser treatment within 4 months or less, and 76% within 2 months or less. Early intervention to minimize pathological scar formation and related disability is an important paradigm shift in traumatic scar treatment, and an essential potential benefit of minimally invasive laser procedures.

Ogawa et al (2022) published an updated algorithms for the treatment and prevention of hypertrophic scars and keloids. Treatment of hypertrophic scars depends on scar contracture severity: if severe, surgery is the first choice. If not, conservative therapies are indicated. Conservative therapies (e.g., gel sheets, tape fixation, topical and injected external agents, should be administered on a case-by-case basis. Keloid treatment depends on whether they are small and single or large and multiple. Small and single keloids can be treated radically by surgery with adjuvant therapy (e.g., radiotherapy) or multimodal conservative therapy. For large and multiple keloids, volume- and number-reducing surgery is a choice. Regardless of the treatment(s), patients should be followed up over the long term.

Otoplasty

According to the American Society of Plastic Surgeons (ASPS), otoplasty is a medically necessary and reconstructive surgery when it is performed to approximate a normal appearance, even if it does not improve function (ASPA 2015).

Pectus Excavatum and Pectus Carinatum

In 2012, the American Pediatric Surgical Association (APSA) issued clinical practice guidelines with recommendation to assist pediatric surgeons and pediatricians in the evaluation and management of children with pectus carinatum.

- Without strong evidence for ideal timing of treatment, expert opinion suggests that the age for operative therapy must be individualized but is typically deferred until pubertal growth in

nearly complete.

- For the compliant pectus deformity, nonoperative compressive orthotic bracing is usually an appropriate first line therapy as it does not preclude the operative option.
- Expert opinion suggests that the noncompliant chest wall deformity or significant asymmetry of the pectus carinatum deformity caused by a concomitant excavatum-type deformity may not respond to orthotic bracing.
- Open surgical reconstructive techniques are acceptable surgical options in the hands of experienced pediatric surgeons
- Unless there is some overwhelming indication for repair, operative repair of pectus chest wall deformities is to be discouraged in children ages 5 years and younger due to the risk of disruption of normal chest wall growth with resultant chest wall restriction.

In 2024, joint specialist societies issued best practice consensus guidelines on the treatment of patients with pectus abnormalities (Dunning et al 2024), including the following recommendations:

- Patients with severe pectus excavatum with a Haller index above 3.25 and objective evidence of cardiac compression benefit physiologically from surgical intervention. (Class I, Level of Evidence B)
- Some patients who experience shortness of breath and exercise intolerance but do not fit the preceding criteria may also benefit from surgery, but other objective parameters should be used to determine the likelihood of improvement in cardiovascular performance. (Class IIb, Level of Evidence C)
- For patients with very severe pectus excavatum and evidence of symptomatic malignant arrhythmias with no other cause identified, surgical treatment is indicated to mitigate the risk of death from that arrhythmia. (Class I, Level of Evidence C)
- Surgery is indicated in patients with syncope or presyncope due to severe pectus excavatum. (Class I, Level of evidence C)
- Patients with very severe pectus excavatum and dysphagia (not otherwise explained by esophageal pathology) should benefit from surgery to relieve these symptoms. (Class IIa, Level of Evidence C)
- Bracing is a highly effective and safe conservative treatment for patients with significant pectus carinatum and must be available to all suitable patients who wish to be treated for their condition. It has fewer risks and is cheaper than an operation and still provides good outcomes. (Class I, Level of Evidence B)

<u>Poland Syndrome (PS)</u>

In 2020, the Italian Association of Poland Syndrome (AISP) issued consensus-based recommendation for diagnosis and medical management of Poland syndrome (Baldelli 2020). AISP reports that there are no strict guidelines or indications regarding thoracic surgery in the current literature. The mandatory feature of PS is the agenesis or hypoplasia of the pectoralis major muscle (the sterno-

costal head is always affected). In most cases, PS is unilateral. Presumed bilateral PS needs a more extensive differential diagnosis. Additional diagnostic criteria are hypo/aplasia of the homolateral mammary gland and nipples, and malformations of the homolateral upper limb (limited to or more severely affecting the central rays).

- The indication for thoracic surgery is usually related to severe rib cage anomalies, either regarding anterior chest wall (pectus excavatum, carinatum or combination of both) or ribs (rib agenesis).
- Respiratory symptoms are not common in PS patients. Lack of protection of lungs and other thoracic organs due to the rib cage defect (rib agenesis) does not indicate per se thoracoplasty during childhood.

Rosacea

The National Rosacea Society's standard management options for rosacea (Thiboutot 2019) and the American Acne & Rosacea Society's update on the management of rosacea (Del Rosso 2019) do not address chemical peels or dermabrasion as treatment options for rosacea.

Vitiligo – Cellular Transplant

The international Vitiligo Task Force issued a consensus position statement, part 2, for specific treatment recommendations (Senschal 2023). Surgery should be reserved for patients with stable vitiligo and other localized and stabilized forms of vitiligo (non-segmental) after the documented failure of medical interventions. Several techniques exist, including punch grafting, suction blister grafting, non-cultured epidermal cellular grafting, and cultured epidermal cellular grafting. Each method has its pros and cons.

REGULATORY STATUS

Not Applicable

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm^2 or part thereof, or 1% of body surface area of infants and children
0480T	each additional 100 cm^2, or each additional 1% of body surface area of infants

Code	Description
	and children, or part thereof (List separately in addition to code for primary procedure)
10040	Acne surgery (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201	each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)
11300	Shaving of epidermal or dermal lesion, single lesion, trunk, arms, or legs; lesion diameter 0.5 cm or less
11301	lesion diameter 0.6 to 1.0 cm
11302	lesion diameter 1.1 to 2.0 cm
11303	lesion diameter over 2.0 cm
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
11306	lesion diameter 0.6 to 1.0 cm
11307	lesion diameter 1.1 to 2.0 cm
11308	lesion diameter over 2.0 cm
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane
11311	lesion diameter 0.6 to 1.0 cm
11312	lesion diameter 1.1 to 2.0 cm
11313	lesion diameter over 2.0 cm
11401 - 11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms, or legs (code range)
11420 - 11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia (code range)
11440 - 11446	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; (code range)
11900	Injection, intralesional; up to and including 7 lesions
11901	more than 7 lesions
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color

Code	Description
	defects of skin, including micropigmentation; 6.0 sq cm or less
11921	6.1 to 20.0 sq cm
11922	each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12051	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
15011 (*E/I)	Harvest of skin for skin cell suspension autograft; first 25 sq cm or less (*E/I for diagnosis codes L80 Vitiligo; H02.73-H02.739; N90.8-N90.89)
15012 (*E/I)	each additional 25 sq cm or part thereof (List separately in addition to code for primary procedure) (*E/I for diagnosis codes L80 Vitiligo; H02.73-H02.739; N90.8-N90.89)
15013 (*E/I)	Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; first 25 sq cm or less of harvested skin (*E/I for diagnosis codes L80 Vitiligo; H02.73-H02.739; N90.8-N90.89)
15014 (*E/I)	each additional 25 sq cm of harvested skin or part thereof (List separately in addition to code for primary procedure) (*E/I for diagnosis codes L80 Vitiligo; H02.73-H02.739; N90.8-N90.89)
15015 (*E/I)	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms, legs; first 480 sq cm or less (*E/I for diagnosis codes L80 Vitiligo; H02.73-H02.739; N90.8-N90.89)
15016 (*E/I)	each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure) (*E/I for diagnosis codes L80 Vitiligo; H02.73-H02.739; N90.8-N90.89)
15017 (*E/I)	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 480 sq cm or less (*E/I for diagnosis codes L80 Vitiligo; H02.73-H02.739; N90.8-N90.89)
15018 (*E/I)	each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)

Code	Description
	(*E/I for diagnosis codes L80 Vitiligo; H02.73-H02.739; N90.8-N90.89)
15769 (NMN)	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
15771 (NMN)	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772 (NMN)	each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15775 (NMN)	Punch graft for hair transplant; 1 to 15 punch grafts
15776 (NMN)	more than 15 punch grafts
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	segmental, face
15782	other than face
15783	superficial, any site (e.g., tattoo removal)
15788 (NMN)	Chemical peel, facial; epidermal
15789 (NMN)	dermal
15792 (NMN)	Chemical peel, nonfacial; epidermal
15793 (NMN)	dermal
15824	Rhytidectomy; forehead
15825	neck with platysmal tightening (platysmal flap, P-flap)
15826 (NMN)	glabellar frown lines
15828	cheek, chin, and neck
15829	superficial musculoaponeurotic system (SMAS) flap
17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq cm
17107	10.0 to 50.0 sq cm
17108	over 50.0 sq cm
17110	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111	15 or more lesions

Code	Description
17340 (E/I)	Cryotherapy (CO2 slush, liquid N2) for acne
17360 (NMN)	Chemical exfoliation for acne (e.g., acne paste, acid)
17380 (NMN)*	Electrolysis epilation, each 30 minutes (*Unless related to gender affirming procedure requests. Refer to Related Policies section for criteria.)
17999 (*NMN)	Unlisted procedure, skin, mucous membrane, and subcutaneous tissue (*NMN when used for laser hair removal, unless related to gender affirming procedure requests. Refer to Related Policies section for criteria.)
19316	Mastopexy
19325	Breast augmentation with implant
21740	Reconstructive repair of pectus excavatum or carinatum; open
21742	minimally invasive approach (Nuss procedure), without thoracoscopy
21743	minimally invasive approach (Nuss procedure), with thoracoscopy
32664	Thoracoscopy, surgical; with thoracic sympathectomy
56620	Vulvectomy simple; partial
56625	complete
64821	Sympathectomy; radial artery
64822	ulnar artery
64823	superficial palmar arch
69090 (NMN)	Ear piercing
69300	Otoplasty, protruding ear, with or without size reduction

HCPCS Codes

Code	Description
C1832 (*E/I)	Autograft suspension, including cell processing and application, and all system components (*E/I for diagnosis codes L80 Vitiligo; H02.73-H02.739; N90.8-N90.89)
J0591 (NMN)	Injection, deoxycholic acid, 1 mg

ICD10 Codes

Code	Description
Multiple Codes	

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SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Actinic Keratoses (NCA CAG-00049N) [accessed 2025 Aug 8]

Laser Procedures (NCD 140.5) [accessed 2025 Aug 8]

Treatment of Actinic Keratosis (AKs) (NCD 250.4) [accessed 2025 Aug 8]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

07/25/02, 12/11/03, 05/27/04, 12/02/04, 12/01/05, 12/07/06, 10/24/07, 10/23/08, 10/28/09, 12/09/10, 12/08/11, 09/04/12, 12/06/12, 12/12/13, 12/11/14, 12/10/15, 02/25/16, 04/27/17, 02/22/18, 02/28/19, 02/27/20, 10/22/20, 02/25/21, 02/17/22, 02/16/23, 02/22/24, 02/20/25, 09/18/25

Date	Summary of Changes

09/18/25	• Off-cycle review. Policy intent unchanged, reformatted and revised criteria related to congenital chest wall repair, scar revision, otoplasty, labiaplasty. Policy Statements were restructured, with clarifying edits. Criteria for subcutaneous injection of filling material was moved to new CMP #7.01.119.
05/22/25	• Policy edit: lipectomy policy content was removed and merged onto CMP #7.01.53.
02/20/25	• Annual review, reformat of the entire policy, policy intent unchanged.
01/01/25	• Summary of changes tracking implemented.
10/18/01	• Original effective date