

## Corporate Medical Policy

### Cosmetic and Reconstructive Surgery

**File Name:** cosmetic\_and\_reconstructive\_surgery  
**Origination:** 8/1979  
**Last Review:** 8/2023

#### Description of Procedure or Service

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Cosmetic procedures are those services intended to improve appearance and not primarily to restore bodily function or to correct significant deformity resulting from accidental injury, trauma, or previous therapeutic process.

Reconstructive procedures are performed on structures of the body for the purpose of improving/restoring bodily function or correcting significant deformity resulting from accidental injury, trauma, or previous therapeutic process.

**Please refer to the BCBSNC specific policies:**

Abdominoplasty and Panniculectomy  
Botulinum Toxin Injection  
Breast Surgeries  
Composite Allotransplantation of the Hand and Face  
Gender Affirmation Surgery and Hormone Therapy  
Laser Treatment of Port Wine Stain  
Non-Pharmacologic Treatment of Rosacea  
Orthognathic Surgery  
Reconstructive Eyelid Surgery and Brow Lift  
Rhinoplasty  
Septoplasty  
Surgical Treatment of Chest Wall Deformities  
Varicose Veins of the Lower Extremities , Treatment for

This policy does not address procedures or treatments related to transgender services. Please see the policy “Gender Affirmation Surgery and Hormone Therapy” for information regarding transgender services.

**\*\*\*Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.**

#### Policy

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**BCBSNC will not provide coverage for cosmetic procedures as defined above.**

**BCBSNC will provide coverage for Reconstructive Procedures when they are determined to be medically necessary because the medical criteria and guidelines shown below are met.**

#### Benefits Application

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# Cosmetic and Reconstructive Surgery

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

Some certificates limit coverage of reconstructive surgery following trauma or injuries occurring while a member.

## **When Cosmetic and Reconstructive Surgery is covered**

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- A.** Reconstructive surgery is covered for **either of the following** indications:
1. The procedure is intended primarily to improve/restore bodily function or to correct significant deformity resulting from accidental injury, trauma, or previous therapeutic process  
**OR**
  2. The procedure is intended to address congenital or developmental anomalies that have resulted in significant functional impairment.
- B.** The following **surgical procedures** would be considered medically necessary and are covered services (not all inclusive):
1. Auricular reconstruction for absent or deformed ears resulting from congenital absence, trauma or accidental injury
  2. Rhytidectomy for the treatment of burns
  3. Chin implant for deformities of the maxilla or mandible resulting from trauma or accidental injury
  4. Excision/treatment of tattoos of traumatic or therapeutic origins
  5. Insertion or injection of prosthetic material for significant deformity from accidental injury or trauma
  6. Repair/revision of significantly symptomatic scars resulting from covered surgery or therapeutic process
  7. Prolarynx Gel® and Prolarynx Plus® for indications of vocal fold medialization and vocal fold insufficiency in accordance with FDA labeling
- C.** The following **dermatological procedures** would be considered medically necessary and are covered services (not all inclusive):
1. Epidermal chemical peels used to treat patients with active acne that have failed a trial of topical and/or oral antibiotic acne therapy
  2. Dermal chemical peels used to treat patients with numerous (>10) actinic keratosis or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical
  3. Laser resurfacing used to treat patients with numerous (>10) actinic keratosis or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical
- D.** Treatment of a keloid is considered medically necessary when there is documented evidence of significant functional impairment related to the keloid and the treatment can be reasonably expected to improve the functional impairment. Treatment of a keloid with superficial radiation therapy up to 3 fractions-is considered medically necessary as adjunct therapy following surgical excision if initiated within 3 days when the medically necessary criteria for keloid removal are met.

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## When Cosmetic and Reconstructive Surgery is not covered

- A. Cosmetic surgery or procedures are not covered at any time. Psychiatric and/or emotional distress are not considered as medically necessary indications for cosmetic procedures. The following **surgical procedures** would be considered cosmetic and are non-covered services (not all inclusive):
1. Otoplasty for large or protruding ears
  2. Hairplasty for any form of alopecia not related to a deformity resulting from accidental injury, trauma, or previous therapeutic process
  3. Rhytidectomy of face for aging skin, neck tuck or lift
  4. Excision/correction of glabellar frown lines
  5. Dermal fillers and volume producing agents such as but not limited to Poly-L-Lactic (Sculptra®/Sculptra® Aesthetic) and Radiesse®
  6. Electrolysis for hirsutism
  7. Chin implant (genioplasty) for deformity not the result of accidental injury or trauma
  8. Insertion or injection of prosthetic material to replace absent adipose tissue
  9. Poly-L-lactic acid injection (Sculptra®/Sculptra Aesthetic®) used for HIV lipoatrophy
  10. Excision/treatment of decorative tattoos
  11. Repair/revision of asymptomatic scars
  12. Treatment of submental fat (double chin) such as but not limited to Kybella™ (deoxycholic acid)
- B. The following **dermatological procedures** would be considered cosmetic and are non-covered services (not all inclusive):
1. Epidermal chemical peels used to treat photoaged skin, wrinkles, or acne scarring
  2. Dermal chemical peels used as treatment of end-stage acne scarring
  3. Laser resurfacing for wrinkling, aging skin, acne vulgaris or telangectasias resulting from rosacea
  4. Dermabrasion for wrinkling or pigmentation or severe acne scarring
  5. Chemical exfoliation for active acne and acne scarring.
- C. Reconstructive surgery or procedures are not covered:
1. When they do not correct a congenital or developmental anomaly that has resulted in significant functional impairment
  2. In the absence of documentation that the procedure was performed primarily to restore/improve bodily function or to correct deformity resulting from accidental injury, trauma, or previous therapeutic process.

**\*\*\*NOTE: BCBSNC does not cover investigational, cosmetic or not medically necessary services and will not reimburse for any services, procedures, drugs or supplies associated with those investigational, cosmetic or not medically necessary services.**

## Policy Guidelines

Any strabismus treatment in individuals 18 years of age or older is covered if the reconstructive criteria are met.

Occasionally, there may be congenital anomalies which do not result in functional impairment but which are so severely disfiguring as to merit consideration for corrective surgery. Examples

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are the cranio-facial anomalies associated with Crouzon's Syndrome and Treacher-Collins Syndrome.

## **Billing/Coding/Physician Documentation Information**

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This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at [www.bcbsnc.com](http://www.bcbsnc.com). They are listed in the Category Search on the Medical Policy search page.

*Applicable service codes: Refer to the individual codes for each specific procedure with the exception of 77401.*

If documentation is requested, it should include the following:

- Medical records indicating that the procedure will be or was performed to restore/improve bodily function or to correct deformity resulting from accidental injury, trauma, or previous therapeutic process. In the absence of this documentation, the surgery or procedure must be considered cosmetic
- Photographs
- Copies of consultations
- Operative reports
- Any other pertinent information

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

## **Scientific Background and Reference Sources**

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BCBSA Medical Policy Reference Manual

Certificate Provisions

North Carolina Senate Bill 714, Provision of Coverage for Reconstructive Breast Surgery Resulting from Mastectomy, July 10, 1997

Medical Policy Advisory Group - 12/2/99

Specialty Matched Consultant Advisory Panel - 7/2000

Medical Policy Advisory Group - 9/14/2000

Specialty Matched Consultant Advisory Panel - 10/2000

Medical Policy Advisory Group - 12/2000

Specialty Matched Consultant Advisory Panel - 9/2002

BCBSA Medical Policy Reference Manual, 8.01.16, 7/12/02

BCBSA Medical Policy Reference Manual, 10.01.09, 7/12/02

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.01.16, 10/9/03

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BCBSA Medical Policy Reference Manual [Electronic Version]. 10.01.09, 10/9/03

van Zuuren, EJ, Graber, MA, Hollis, S, Chaudhry, M, Gupta, AK. (2004) Interventions for rosacea. The Cochrane Library, Issue 2. Retrieved on 5/11/04 from <http://212.49.218.203/newgenMB/ASP/Document.asp?docNo=977>.

Specialty Matched Consultant Advisory Panel - 7/2004

Specialty Matched Consultant Advisory Panel - 6/2006

Medical Director Review 7/2007

Specialty Matched Consultant Advisory Panel - 5/29/08

Senior Medical Director Review - 9/2009

Specialty Matched Consultant Review - 7/2009

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.40, 6/10/10

Specialty Matched Consultant Advisory Panel review 9/2010

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.01.16, 7/14/11

Specialty Matched Consultant Advisory Panel review 9/2011

Medical Director review 8/2012

Specialty Matched Consultant Advisory Panel review 9/2012

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.01.16, 7/12/12

Strauss JS, Krowchuk DP, Leyden JJ, et al. American Academy of Dermatology. Guidelines of care for acne vulgaris management. J Am Acad Dermatol. 2007;56-651-653. Retrieved from <http://www.aad.org/education-and-quality-care/clinical-guidelines/current-and-upcoming-guidelines/current-guidelines-and-guidelines-in-development>

Kim RH, Armstrong AW. Current state of acne treatment: highlighting lasers, photodynamic therapy, and chemical peels. Dermatol Online J. 2011 Mar 15;17(3):2. Retrieved from [http://dermatology.cdlib.org/1703/2\\_reviews/2\\_11-00063/article.html](http://dermatology.cdlib.org/1703/2_reviews/2_11-00063/article.html)

Medical Director review 4/2013

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.01.16, 7/11/13

Specialty Matched Consultant Advisory Panel review 9/2013

Feldman SR, Fleischer AB Jr. Progression of actinic keratosis to squamous cell carcinoma revisited: clinical and treatment implications. Cutis. 2011 Apr;87(4):201-7.

Uhlenhake EE. Optimal treatment of actinic keratoses. Clin Interv Aging. 2013;8:29-35. doi: 10.2147/CIA.S31930.

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.01.16, 7/10/14

Specialty Matched Consultant Advisory Panel review 9/2014

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Medical Director review 9/2014

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.01.16, 7/9/15

Specialty Matched Consultant Advisory Panel review 9/2015

Medical Director review 9/2015

U.S. Food and Drug Administration (FDA). Center for Devices and Radiological Health (CDRH). Juliesse™ Injectable Laryngeal Implant. 510(k) K060815. Updated April 18, 2006. Accessed November 19, 2015. Available at URL address:  
[http://www.accessdata.fda.gov/cdrh\\_docs/pdf6/K060815.pdf](http://www.accessdata.fda.gov/cdrh_docs/pdf6/K060815.pdf)

Medical Director review 9/2016

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.01.16, 12/08/2016

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.01.16, 12/14/2017

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.01.16, 7/1/2019

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.01.16, 12/12/2019

Specialty Matched Consultant Advisory Panel 8/2020

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.01.16, 1/2021

Specialty Matched Consultant Advisory Panel 8/2021

Medical Director review 8/2021

Medical Director review 9/2021

Medical Director review 8/2022

Specialty Matched Consultant Advisory Panel 8/2022

Medical Director review 8/2023

Specialty Matched Consultant Advisory Panel 8/2023

## **Policy Implementation/Update Information**

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8/79	Original policy
6/83	Reaffirmed
3/85	Reaffirmed
4/86	Reaffirmed with revisions
9/88	Reaffirmed with revisions

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3/89 Reaffirmed with revisions

## Local Review Dates

1/93 Reviewed: PCP Physician Advisory Group

11/93 Reviewed: PCP Physician Advisory Group

11/95 Reviewed: PCP Physician Advisory Group

2/97 Revised: Hairplasty may be reconstructive if for permanent alopecia. References to local policies for blepharoplasty, otoplasty, removal of breast tissue for male gynecomastia and PUVA

8/97 Revised: Added statement under Policy section regarding Post-mastectomy reconstruction, "Reconstruction of the contralateral (non-diseased) breast may be necessary to achieve symmetry between the two breasts and would be eligible for coverage" based on NC Senate Bill 714.

12/97 Revised: Notation regarding Medical Policy for Reconstructive Breast Surgery Post Mastectomy, (L)19324 added.

2/98 Revised: Notation added regarding Medical Policy for Rhinoplasty, (L)30420.SUR

7/99 Reformatted, Medical Term Definitions added.

12/99 Reaffirmed, Medical Policy Advisory Group

7/00 Specialty Matched Consultant Advisory Panel. No changes to criteria.

9/00 Medical Policy Advisory Group review. Approve. No change in criteria. Typographic errors corrected.

12/00 Specialty Matched Consultant Advisory Group review. Examples of Cosmetic and Reconstructive procedures table reworked for clarity. Added telangiectasis, spider veins, congenital vascular malformations or Port Wine Stains to table. Medical Policy Advisory Group review. No change in criteria. Approve.

1/01 Added reference to Cosmetic and Reconstructive Procedures table to refer reader to Venous Insufficiency policy and Laser Treatment of Congenital Vascular Malformations for additional information. No change in criteria.

11/01 Coding format change.

4/02 Policy reformatted for clarity. Laser resurfacing added to Examples of Cosmetic and Reconstructive Procedures table. No change to Billing/Coding Section.

10/02 Specialty Matched Consultant Advisory Panel review. Added "or when future cardiovascular compromise is anticipated" to Reconstructive Procedures column for Pectus Excavatum. Added additional information concerning dermal and epidermal chemical peels, and panniculectomy. Removed reference to policy on Laser Treatment of Congenital Vascular Malformations.

5/13/04 Benefits Application and Billing/Coding sections updated for consistency. Statement added in grid under Cosmetic Procedures indicating that laser resurfacing for

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telangiectasias resulting from rosacea is cosmetic. Notification given 5/13/04.  
Effective date 7/15/04.

- 8/12/04 Specialty Matched Consultant Advisory Panel review 7/14/2004. No changes to criteria. Added "or" under section When Cosmetic and Reconstructive surgery is covered at the end of B. 1. for clarification. Removed product names from Reconstructive Procedures table, Blepharoplasty. Now states "Prior approval may be required." References added.
- 7/24/06 Specialty Matched Consultant Advisory Panel review 6/20/2006. Added "Laser resurfacing used to treat patients with numerous (>10) actinic keratosis or other premalignant skin lesions, such that treatment of the individual lesions becomes impractical." under "Reconstructive" indications. Added additional criteria to the reconstructive indication for panniculectomy to indicate; "A panniculectomy may be considered reconstructive when the pannus hangs at or below the level of the pubic symphysis and causes recurrent and significant bacterial cellulitis, that requires at least 2 treatments with an oral antibiotic and is unresponsive to conservative treatment including adequate hygiene and topical anti-infective medications over a 6 month period resulting in fibrosis and thickening of the pannus with discoloration and/or lymphedema or peau d'orange effect (pitting or prominence or pore due to fibrosis and swelling) of the overlying skin. If there has been a significant weight loss (>100lbs) the member must have maintained a stable weight for a minimum of 6 months. If the weight loss is a result of bariatric surgery a panniculectomy should not be performed until at least 18 months after surgery and only after weight has been stable for the most recent 6 months. Panniculectomy may be medically necessary when considered a critical part of a surgical repair of a clinically significant (>5cm) ventral or umbilical hernia . Photographs and documentation may be required." Updated names of specific referenced Medical Policies as appropriate. Added "liposuction, tummy tuck, lift" to "Key Words" section.
- 8/28/06 Revised the section under "Examples of Cosmetic and Reconstructive Procedures" regarding "panniculectomy" for clarification.
- 8/13/07 Updated references in policy to "disease" and replaced with the wording "accidental injury" for consistency with the benefit language definition of cosmetic. Added new information to "Examples of Cosmetic and Reconstructive Procedures" indicating "Dermal fillers and volume producing agents such as but not limited to Poly-L-Lactic (Sculptra) and Radiesse " under "Cosmetic" and "Dermal fillers and volume producing agents such as but not limited to Poly-L-Lactic (Sculptra) and Radiesse are not reconstructive as they are specifically used to improve appearance." Added "severe acne scarring" to "Dermabrasion" as Cosmetic and "Not reconstructive". Added reference to the Medical Policy entitled "Collagen Implantation" in relation to "Insertion or injection of prosthetic material to replace absent adipose tissue." Added "UVB light box, and any other light therapy" to "Psoralent ultraviolet A (PUVA) for the treatment of vitiligo". Removed reference to the medical policy entitled PUVA (Psoralens with Ultraviolet A) Therapy. Under "Policy Guidelines" added the following statement; "Poly-L-lactic acid injection (Sculptra) used for HIV lipoatrophy is considered cosmetic because the sole purpose is to improve appearance and it does not restore physiological function." "Key Words" updated.
- 5/19/08 Under "Examples of Cosmetic and Reconstructive Surgery", revised statement "Telangiectasis or spider veins. Refer to Medical Policies entitled Varicose Vein Excision and Ligation, Endoluminal Radiofrequency or Laser Ablation of Varicose Veins, and Sclerotherapy as a Treatment of Varicose Veins for policy guidelines." to indicate the new combined policy entitled "Varicose Veins, Treatment for".



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- 7/28/08 Specialty Matched Consultant Advisory Panel review 6/23/08. Added comment related to "hairplasty" under the "Reconstructive Procedures" section that indicates; "When meets the definition of reconstruction". Added "Refer to Medical Policy entitle Non-Pharmacologic Treatment of Rosacea, MED1307" in regards to "Epidermal chemical peels". Added "acne vulgaris" to the "Cosmetic Procedures" section regarding "Laser resurfacing". Reworded "A.2." in regards to reconstructive panniculectomy from; "causes recurrent and significant bacterial cellulitis, that has failed at least 2 treatments with an oral antibiotic." to "causes bacterial cellulitis that has failed to respond or recurred after at least two courses of antibiotic treatment." References added.
- 5/18/09 Added reference to " policy number SUR6684, Surgical Treatment of Chest Wall Deformities (Congenital or Acquired). " to "Pectus Excavatum" section in table.
- 9/28/09 Added ""\*\*\*NOTE: BCBSNC does not cover investigational, cosmetic or not medically necessary services and will not reimburse for any services, procedures, drugs or supplies associated with those investigational, cosmetic or not medically necessary services." to the "When Not Covered" section for clarification. Updated the definition of "congenital" from "existing at, and usually before, birth; referring to conditions that are present at birth, regardless of their causation." to "existing at, and usually before, birth; referring to conditions that are apparent at birth, regardless of their causation." to be consistent with the member benefit booklet language. Reviewed with Senior Medical Director 9/2/09. (btw)
- 9/28/09 Reformatted information related to medical necessity for panniculectomy and added a requirement of "a BMI of <35". Also added informational note indicating; "The majority of requests for coverage for panniculectomy are for patients who have sustained significant weight loss, or who remain morbidly obese. Because surgical outcomes are superior when performed in patients who have achieved stable weight loss, BCBSNC requires that stable weight loss with BMI less than 35 be obtained prior to authorization of coverage for panniculectomy surgery, except in rare, unusual cases." Reviewed with Senior Medical Director 9/2/09. Notice given 9/28/09. Policy effective 1/5/10. (btw)
- 6/22/10 Policy Number(s) removed (amw)
- 9/14/10 Revised comments regarding Telangiectasis or spider veins under the Reconstructive Procedures that states, "Laser treatment of port wine stains in the presence of functional impairment related to the port wine stain may be considered medically necessary. Refer to Medical Policy entitled, Laser Treatment of Port Wine Stain for policy guidelines." Reference added. (mco)
- 10/26/10 Specialty Matched Consultant Advisory Panel review 9/2010. Replaced "vaccination" with "asymptomatic" under "Repair/revision of scars" in Cosmetic Examples table. References updated. Reformatted the Billing/Coding section. (mco)
- 10/25/11 Removed ear piercing from section of policy titled, "Examples of Cosmetic and Reconstructive Surgery." Under Reconstructive section for Otoplasty, added "congenital absence." The following information was removed from the section titled, "Telangiectasis or spider veins" and is now a distinct category: "Laser treatment of port wine stains in the presence of functional impairment related to the port wine stain may be considered medically necessary. Refer to Medical Policy entitled, Laser Treatment of Port Wine Stain for policy guidelines." Removed "dry eye" from the Reconstructive section of lower lid blepharoplasty and added the following conditions: "disease due to ectropion, entropion or trichiasis." Specialty Matched Consultant Advisory Panel review 9/2011. References updated. (mco)

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- 5/15/12 Removed information regarding treatment of vitiligo from section titled “Examples of Cosmetic and Reconstructive Surgery” Please see separate BCBSNC policy titled, “Light Treatment for Dermatologic Conditions.” Medical Director review. (mco)
- 10/16/12 Policy extensively revised. The following related BCBSNC policies are referenced in the Description section: Reconstructive Eyelid Surgery and Brow Lift, Rhinoplasty, Septoplasty, Non-Pharmacologic Treatment of Rosacea, Hyperhidrosis, Treatment of, Prosthetic Appliances, Breast Surgeries, Varicose Veins, Treatment for, Surgical Treatment of Chest Wall Deformities, Laser Treatment of Port Wine Stain, Abdominoplasty, Panniculectomy and Lipectomy, Orthognathic Surgery, Gender Reassignment Surgery, Botulinum Toxin Injection, Ultrasonographic Evaluation of Skin Lesions. Information regarding procedures specific to the related policies has been deleted from this policy. Deleted the table titled, “Examples of Cosmetic and Reconstructive Surgery.” Examples of surgical and dermatological reconstructive procedures have been relocated to the “When Covered” section. Examples of surgical and dermatological cosmetic procedures have been relocated to the “When not Covered” section. Medical Director review 8/2012. Specialty Matched Consultant Advisory Panel review 9/2012. (mco)
- 5/14/13 References updated. Added related policy to Description section: “Composite Allotransplantation of the Hand and Face.” Added the following service to the “When Not Covered” section: “Chemical exfoliation for active acne and acne scarring.” Medical Director review 4/2013. Notification given 5/14/13 for effective date of 8/13/13. (mco)
- 10/15/13 Specialty Matched Consultant Advisory Panel review 9/2013. Revised “When not Covered”: section A2 to state: “Hairplasty for any form of alopecia not related to a deformity resulting from accidental injury, trauma, or previous therapeutic process.” Medical Director review 9/2013. References updated. (mco)
- 8/26/14 References updated. No changes to Policy Statements. (mco)
- 10/14/14 Specialty Matched Consultant Advisory Panel review 9/2014. Medical Director review 9/2014. Added Sculptra® Aesthetic to the “When not Covered” section. No changes to Policy statements. (mco) (td)
- 5/26/15 When Not Covered section updated to include: “Treatment of submental fat (double chin) such as but not limited to Kybella™ (deoxycholic acid)”. Policy Statement remains unchanged. (td)
- 10/30/15 Specialty Matched Consultant Advisory Panel review 9/30/2015. Medical Director review 9/2015. (td)
- 12/30/15 When Covered section B. updated to include this statement, “Prolaryn Gel® and Prolaryn Plus® for indications of vocal fold medialization and vocal fold insufficiency in accordance with FDA labeling”. References updated. Policy Statement unchanged. (td)
- 10/25/16 In the “When Covered” section, Item B.1. the word “otoplasty” changed to “auricular reconstruction.” Specialty Matched Consultant Advisory Panel review 9/28/2016. (an)
- 9/15/17 Specialty Matched Consultant Advisory Panel review 8/30/2017. No change to policy statement. (an)

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- 9/7/18 Wording change in When Covered section, Item A. 2.: the word “correct” was changed to “address”. Reference added. Specialty Matched Consultant Advisory Panel review 8/22/2018. No change to policy statement. (an)
- 9/10/19 Specialty Matched Consultant Advisory Panel 8/20/19. No change to policy statement. (eel)
- 9/8/20 Specialty Matched Consultant Advisory Panel 8/19/20. References updated. No change to policy statement. (eel)
- 9/7/21 Specialty Matched Consultant Advisory Panel 8/2021. Medical Director review 8/2021. (jd)
- 10/19/21 When Cosmetic and Reconstructive Surgery is covered section updated to state “Treatment of a keloid is considered medically necessary when there is documented evidence of significant functional impairment related to the keloid and the treatment can be reasonably expected to improve the functional impairment. Treatment of a keloid with superficial radiation therapy up to 3 fractions is considered medically necessary as adjunct therapy following surgical excision initiated within 3 days when the medically necessary criteria for keloid removal are met.” Billing/Coding section updated to include code 77401. Medical Director review 9/2021. **Notification given 10/19/2021 for effective date 1/1/2022.** (tt)
- 3/31/22 Removed “Hyperhidrosis, Treatment of” from related policies section. No change to policy statement. (tt)
- 10/18/22 Updated policies in description section for clarity. References updated. Specialty Matched Consultant Advisory Panel 8/2022. Medical Director review 8/2022. No change to policy statement. (tt)
- 8/29/23 References updated. Specialty Matched Consultant Advisory Panel 8/2023. Medical Director review 8/2023. No change to policy statement. (tt)

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Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.