



Medical Policy
Reconstructive and Cosmetic Procedures

Document Number: 012

	Commercial and Qualified Health Plans	MassHealth
Authorization required	X	X
No Prior Authorization		

Overview

The purpose of this document is to describe the guidelines AllWays Health Partners utilizes to determine medical appropriateness of procedures considered reconstructive and cosmetic in nature. The treating specialist must request prior authorization for reconstructive and cosmetic procedures.

Coverage Guidelines

AllWays Health Partners generally provides coverage when the surgery or procedure is reconstructive in nature, i.e. needed to improve the functioning of a body part, treat an associated medical complication, or is otherwise medically necessary, even if the surgery or procedure may also improve or change the appearance of a portion of the body. While this policy addresses many common procedures, it does not address all specific procedures that may be considered cosmetic in nature, and therefore excluded from coverage. AllWays Health Partners reserves the right to deny coverage for any procedures that are considered cosmetic and not medically necessary. AllWays Health Partners excludes coverage of cosmetic surgery and procedures that are performed primarily to improve or enhance a person’s appearance as not medically necessary.

AllWays Health Partners covers medically necessary reconstructive surgery and procedures performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease when there is a physical functional impairment or ongoing medical complication that is expected to be improved upon with the requested procedure. AllWays Health Partners will also consider reconstructive/restorative procedures of the face to correct severe disfigurement under the circumstances described below. AllWays Health Partners covers reconstructive surgery, subject to benefit limitations.

Reconstructive procedures require prior authorization in order to determine the benefit coverage and/or the medical necessity of the procedure. Simultaneous procedures may be medically necessary to provide functional improvement. When more than one procedure is requested, documentation that satisfies the criteria for each procedure must be submitted before services are authorized. For some conditions, a planned staged procedure may be medically appropriate, but for most conditions, only the initial reconstructive procedure will be authorized unless a significant functional impairment or ongoing medical complication remains, and medical review criteria are met.

Members must meet the general coverage criteria and the criteria for any specific procedure below:



Eyelid(s)

- Blepharoplasty/Upper Blepharoptosis Repair for visual field impairment
- Upper or Lower Blepharoplasty for Non-Visual Field issues
- Brow Ptosis Repair

Nose

- Rhinoplasty
- Septoplasty

Facial

- See Oral and Maxillofacial Surgery and Procedures Medical Policy

Chest

- See *Breast Surgeries Medical Policy* for Breast Surgeries and tattooing an areola
- Pectus excavatum
- Pectus carinatum
- Poland syndrome

Abdomen

- Panniculectomy

Skin

- Skin Redundancy: Removal on arms, legs, and buttocks
- Dermabrasion
- Scar Revision
- Skin lesion Removal
- Congenital Pigmented Nevi with possible increased malignancy potential
- Skin Tag Removal
- Hemangioma Destruction
- Port Wine Stain Treatment by Laser

Appendages

- Supernumerary Digit Removal

Veins

- Varicose Vein Treatment

General Coverage Criteria

AllWays Health Partners covers medically necessary reconstructive procedures when the following are met:

1. The medical condition or complication and the functional impairment is well documented by supportive testing and clinical notes (photos may be required, and when required may need to be emailed or mailed for visual clarity and quality); and
 - a. If the procedure is listed above or in the criteria below, the specific criteria must also be met; or
 - b. If the procedure is not listed above or in the criteria below, the medical necessity will be reviewed on an individual basis.



2. The requested procedure can be reasonably expected to resolve the medical condition or complication and functional impairment.

Note: For some conditions, a planned staged procedure may be medically appropriate, but for most conditions only the initial reconstructive procedure will be authorized unless a significant functional impairment or ongoing medical complication remains, and medical review criteria are met.

Trauma to the Face

AllWays Health Partners covers medically necessary restorative procedure for the face when the all of the following are met:

1. The circumstances of the accidental trauma and the degree of injury are well documented by supportive testing and clinical notes. (Photos may be required, and when required, may need to be emailed or mailed for visual clarity and quality).
2. The procedure must be requested and performed within 18 months of the accidental injury; or
 - a. For children who have not reached full maturity (i.e. age 16 or less), the medical record must document that a delay greater than 18 months for performing the initial restorative procedure was required in order for growth to be complete; or
 - b. For any other delay greater than 18 months, the medical record must document that the postponement of the initial restorative procedure was required in order for optimal reconstruction, healing, and remodeling.
3. The requested procedure can be reasonably expected to have a successful outcome.

Note: Only the initial restorative procedure will be authorized, unless a significant functional impairment or ongoing medical complication remains, and medical review criteria for a reconstructive procedure are met.

Exclusions

[See General Exclusions](#)

Specific Criteria for Selected Reconstructed Procedures

Eyes

Blepharoplasty/Upper Blepharoptosis Repair for visual field impairment

As of February 20, 2017, medical necessity for Blepharoplasty is determined through InterQual® criteria. To access the criteria, log in to AllWays Health Partners' provider website at allwaysprovider.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Exclusions

[See General Exclusions](#)

Upper or Lower Blepharoplasty for Non-Visual Field issues

As of February 20, 2017, medical necessity for upper or lower blepharoplasty for non-visual field issues is determined through InterQual® criteria. To access the criteria, log in to AllWays Health Partners' provider website at allwaysprovider.org and click the InterQual® Criteria Lookup link under the Resources Menu.



Exclusions

[See General Exclusions](#)

Brow Ptosis Repair

As of February 20, 2017, medical necessity for brow ptosis repair is determined through InterQual® criteria. To access the criteria, log in to AllWays Health Partners' provider website at allwaysprovider.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Nose

Rhinoplasty

As of February 20, 2017, medical necessity for rhinoplasty is determined through InterQual® criteria. To access the criteria, log in to AllWays Health Partners' provider website at allwaysprovider.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Exclusions

[See General Exclusions](#)

Septoplasty

As of February 20, 2017, medical necessity for septoplasty is determined through InterQual® criteria. To access the criteria, log in to AllWays Health Partners' provider website at allwaysprovider.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Chest

Pectus Excavatum

As of February 20, 2017, medical necessity for pectus excavatum repair is determined through InterQual® criteria. To access the criteria, log in to AllWays Health Partners' provider website at allwaysprovider.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Pectus Carinatum

Surgical repair is generally not medically necessary, as the condition is asymptomatic in the vast majority of people. AllWays Health Partners covers medically necessary surgical repair when:

1. The member has a chest wall deformity causing functional impairment such as diminished exercise tolerance or respiratory compromise;
2. The medical record clearly documents the degree of deformity (via Haller index or other) and its direct relationship to the symptoms including supportive cardiopulmonary testing such as pulmonary function testing; and;
3. The member has completed bone growth, generally when greater than or equal to 15 years of age.

Exclusions

1. Male pectoral augmentation for the purpose of enhancing the chest region unrelated to the surgical repair of the chest wall as covered in this policy or the Breast Surgeries policy.
2. See [General Exclusions](#)



Poland Syndrome

See Breast Surgeries Clinical Coverage Criteria for breast reconstruction for members with Poland Syndrome. AllWays Health Partners covers medically necessary surgical repair of associated chest wall deformity when one of the following are met:

1. The member has a chest wall deformity causing functional impairment such as diminished exercise tolerance or respiratory compromise; or
2. The medical record documents chest wall defects in which the chest viscera are exposed and susceptible.

Exclusions

1. Costal aplasia or hypoplasia without physical functional impairment.

Abdomen

Panniculectomy

As of February 20, 2017, medical necessity for panniculectomy of the abdomen is determined through InterQual® criteria. To access the criteria, log in to AllWays Health Partners' provider website at allwaysprovider.org and click the InterQual® Criteria Lookup link under the Resources Menu. Photo documentation is required.

Exclusions

1. Abdominoplasty.
2. [See General Exclusions](#)

Skin

Skin Redundancy: removal on arms, legs, and buttocks

See panniculectomy above for removal of redundant skin of abdomen. See *Breast Surgeries Medical Policy* for breast reduction criteria.

AllWays Health Partners covers medically necessary removal of redundant skin when criteria 1 and 2 are met:

1. The redundant skin is the result of weight loss of at least 75 pounds that has been stable for at least 6 months, and if the weight loss occurs as a result of bariatric surgery, the member must be at least 12 months post bariatric surgery.
2. There is written and photographic supporting documentation that the occlusive redundant skin directly causes one of the following:
 - a. Symptomatic intertriginous ulcerations or macerations that are unresponsive to good personal hygiene and well documented optimal physician-supervised local treatment and that continually persist for a period of at least six months despite this care and treatment. Required lateral and frontal photos must demonstrate a significantly redundant and occlusive skin fold, and additional photos must document the presence of intertriginous skin ulceration and maceration; or
 - b. Recurrent bacterial skin infections (at least 2 in a 12-month period) directly related to the redundant skin, which required systemic antibiotics. Required lateral and frontal photos must demonstrate a significantly redundant and occlusive skin folds.



Note: Liposuction is often an integral part the surgical removal of excessive skin this is not separately reimbursed.

Exclusions

See [General Exclusions](#)

Dermabrasion

AllWays Health Partners covers medically necessary dermabrasion:

1. To remove superficial basal cell carcinomas and pre-cancerous actinic keratoses when conventional methods of treatment (cryotherapy, curettage, excision, and 5-FU) are impractical due to the number and distribution of the lesions, or
2. For restoration after previous medically necessary surgery.

Exclusions

1. Dermabrasion or other cosmetic dermatologic procedures performed for the removal of acne, acne scars, wrinkles, or uneven pigmentation is not considered medically necessary and is not a covered benefit.
2. See [General Exclusions](#)

Scar Revision (including Keloid Revision)

As of February 20, 2017, medical necessity for scar revision is determined through InterQual® criteria. Photo documentation may be required. To access the criteria, log in to AllWays Health Partners' provider website at allwaysprovider.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Skin Lesion Removal

AllWays Health Partners covers medically necessary skin lesion removal in the following situations:

1. Any lesion clinically suspicious for malignancy;
2. Any presumably benign lesion that grows or enlarges, begins to bleed, or ulcerate or that is exposed to frequent irritation; or
3. Nevi when the rationale is to reduce the risk of malignant transformation.

Notes: Photo documentation may be required.

The following *does not require prior authorization*:

- Biopsy, skin lesion biopsy, skin lesion, each additional
- Excisions and simple closure, benign lesions
- Excision, malignant lesions
- Injection into skin
- Destruction of benign lesion(s) other than skin tags or cutaneous vascular proliferative lesions

Exclusions

See [General Exclusions](#)

Skin Tag Removal

AllWays Health Partners covers medically necessary removal of a skin tag. The medical record should clearly document the size, location, and characteristics of the skin tag and one or more of the following conditions is present:

1. Chronic, recurrent, or persistent bleeding, intense itching, and/or pain.
2. Physical evidence of inflammation, e.g.; purulence (containing pus), oozing, edema, erythema (redness).
3. There is a clinical uncertainty as to the likely diagnosis, particularly where malignancy (cancer) is a realistic consideration based on the appearance or growth.
4. The skin tag is in an anatomical region subject to recurrent physical trauma and that such trauma has, in fact, occurred.
5. The skin tag obstructs an orifice or clinically restricts vision.
6. A preauricular skin tag containing both skin and cartilage

Note: Skin tag removal *does not require prior authorization*.

Hemangioma Destruction

AllWays Health Partners covers medically necessary hemangioma destruction when the medical record clearly documents the size, location, and characteristics of the hemangioma and **one** of the following:

1. The hemangioma is causing a functional impairment of vital structures (e.g. impaired vision or astigmatism due to eyelid or periorbital hemangiomas; auditory impairment and secondary speech delay due to hemangiomas in the ear); or
2. The hemangioma has recurrent bleeding, ulceration, or infection; or
3. The hemangioma is pedunculated; or
4. The hemangioma is associated with Kasabach-Merritt syndrome.

Note: photo documentation may be required.

Exclusions

1. Treatment (i.e. laser) of congenital capillary hemangiomas that are naturally resolving and in the absence of interference with a vital structure (eye, airway) or with documented recurrent infection or significant bleeding requiring medical intervention.
2. See [General Exclusions](#)

Port Wine Stain Treatment by Laser

AllWays Health Partners covers medically necessary port wine stain treatment by laser when the medical record clearly documents the size, location, and characteristics of the port wine stain, and one of the following:

1. The port wine stain is on the face and neck; or
2. The port wine stain has recurrent bleeding, ulceration, or infection.

Note: photo documentation may be required.

Exclusions



See [General Exclusions](#)

Appendages

Supernumerary Digit Removal

AllWays Health Partners covers medically necessary removal of supernumerary digits for members up to the age of 19 years.

Exclusions

1. The member is over 19 years of age.
2. See [General Exclusions](#)

Veins

Varicose Vein Ligation and Stripping, Ablation, Ambulatory Phlebectomy, Sclerotherapy

Medical necessity for varicose vein treatment is determined through InterQual® criteria. For MassHealth members these criteria are based “MassHealth Guidelines for Medical Necessity Determination for Treatment of Varicose Veins of The Lower Extremities.” Photo documentation may be required. To access the criteria, log in to AllWays Health Partners’ provider website at allwaysprovider.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Exclusions

See [General Exclusions](#)

General Exclusions

AllWays Health Partners does not provide coverage for reconstructive procedures for conditions that do not meet the criteria noted above, including but not limited to:

1. Coverage of cosmetic surgery and procedures and non-surgical **cosmetic dermatology** procedures that are solely to enhance a patient’s appearance in the absence of any signs or symptoms of functional abnormalities; and/or associated medical complication is considered cosmetic and is not a covered benefit, unless specifically noted otherwise in this coverage criteria.
2. Any procedure where the primary purpose is to enhance aesthetics, including but not limited to:
 - a. Hair removal
 - b. Hair transplantation
 - c. Liposuction
 - d. Facial implants
 - e. Calf implants
 - f. Skin tightening
 - g. Chemical peels
 - h. Laser skin resurfacing

Note: please for procedures involving Gender Reassignment please refer to the Gender Reassignment Services policy.
3. Thyroid cartilage shaving surgeries or procedures performed primarily for psychological or emotional reasons.
4. Liposuction for lipedema

Related Policies

- [Breast Surgeries Medical Policy](#)
- [Oral and Maxillofacial Surgery and Procedures Medical Policy](#)
- [Phototherapy and Photochemotherapy for Dermatologic Conditions Medical Policy](#)
- [Dermatology Provider Payment Guidelines](#)

CPT/HCPC Codes

Authorized CPT/HCPCS Codes	Code Description
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad

15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
26567	Osteotomy; phalanx of finger, each
26587	Reconstruction of polydactylous digit, soft tissue and bone
28344	Reconstruction, toe(s); polydactyly
30120	Excision or surgical planing of skin of nose for rhinophyma
30220	Insertion, nasal septal prosthesis (button)
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair

30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)
30630	Repair nasal septal perforations
30930	Fracture nasal inferior turbinate(s), therapeutic
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated (Not Reimbursed for MassHealth Plans)
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) (Not Reimbursed for MassHealth Plans)
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
37718	Ligation, division, and stripping, short saphenous vein
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia
37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open, 1 leg

37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)
37785	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg
67715	Canthotomy (separate procedure)
67830	Correction of trichiasis; incision of lid margin
67835	Correction of trichiasis; incision of lid margin, with free mucous membrane graft
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
67909	Reduction of overcorrection of ptosis
67911	Correction of lid retraction
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)
67914	Repair of ectropion; suture
67915	Repair of ectropion; thermocauterization
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (eg, tarsal strip operations)
67973	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, 1 stage or first stage

67974	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, upper, 1 stage or first stage
67975	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; second stage
69300	Otoplasty, protruding ear, with or without size reduction

Effective

March 2020: Annual review. Added exclusion Liposuction for lipedema. References updated.

June 2019: Off-cycle review. Added MassHealth language for Varicose Veins. Adopted MassHealth guidelines for MassHealth members. Updated References section.

January 2019: Annual review. Added CPT codes. Updated references.

December 2017: Annual review. Updated time requirement from 12 months to 18 months, under trauma to the face.

May 2017: Changes reflect the addition of InterQual® varicose veins treatment criteria.

February 2017: Changes reflect the addition of InterQual® eye, nose, chest, abdomen, and scar revision criteria.

October 2016: Annual review.

October 2015: Annual Review and updates included expanded list of cosmetic surgery and procedures and non-surgical **cosmetic dermatology** procedures for the primary purpose of enhancing aesthetics, and clarification of varicose vein criteria References updated.

October 2014: Annual review. Updates included reformatted and clarified criteria. Added general criteria, criteria for the face, skin redundancy removal to arms legs and buttocks, and new criteria for varicose veins. Added procedures under coverage guidelines.

March 2013: Annual review.

February 2012: Annual review.

February 2011: Annual review.

January 2010: Annual review.

January 2009: Annual review.

January 2008: Annual review.

January 2007: Annual review.

December 2006: Annual review.

November 2005: Effective Date.

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