Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Reconstructive and Cosmetic Surgery

Effective: August 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☒ No ☐
Notification Required	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether
- Tufts Health One Care

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Harvard Pilgrim Health Care Members:

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Researched and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the instructions here). Members may access materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742.

For Tufts Health Plan Members:

To obtain InterQual® SmartSheets™"

- Tufts Health Plan Commercial Plan products: If you are a registered Tufts Health Plan provider click here to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404
- Tufts Health Public Plans products: InterQual® SmartSheet(s) available as part of the prior authorization process

Tufts Health Plan requires the use of current InterQual® Smartsheet(s) to obtain prior authorization.

In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan

Overview

The Plan may provide coverage for reconstructive surgery and procedures when they meet Medical Necessity Guidelines and are determined to be Medically Necessary as defined below.

I. Procedures included in this policy with The Plan MEDICAL NECESSITY guidelines:

A. General Reconstructive and Cosmetic Surgery[+]
B. Redundant Skin – Surgical Removal (includes Panniculectomy)[+√]
C. Hemangioma and Port Wine Stain Treatments
D. Hair Removal by Laser or Electrolysis
E. Labiaplasty
F. Breast Reconstruction

II. Procedures included in this policy which require an InterQual SmartSheet:

A. Breast Implant Removal*^[+]
B. Gynecomastia: Surgical Correction by Mastectomy, Male*^[+]
C. Reduction Mammoplasty for Symptomatic Macromastia, Female*^[+]
D. Rhinoplasty*^[+×]
E. Scar Revision^

[*]Procedures for which Harvard Pilgrim Health Care uses InterQual criteria
[^]Procedures for which Tufts Health Plan uses InterQual criteria
[+]Procedures for which Tufts Health One Care utilizes guidance from the Centers for Medicare and Medicaid Services
[√]Procedures for which Tufts Together utilizes guidance from the Mass Health Guidelines for Medical Necessity Determination for Excision of Excessive Skin and Subcutaneous Tissue Mass Health Guidelines for Guidelines for Medical Necessity Determination for Excision of Excessive Skin and Subcutaneous Tissue
[×]Procedures for which Tufts Together utilizes guidance from the Mass Health Guidelines for Rhinoplasty, MassHealth Guidelines for Medical Necessity Determination for Rhinoplasty and Septoplasty | Mass.gov

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations. For **Tufts Health One Care** plan members, the following is used:

- General Cosmetic and Reconstructive Surgery, Rhinoplasty, Gynecomastia, Breast Implant Removal, Breast Reduction, and Panniculectomy (as evident by the [+] above) LCD - Cosmetic and Reconstructive Surgery (L39051) (cms.gov)
- Redundant Skin MassHealth Guidelines for Medical Necessity Determination for Excision of Excessive Skin and Subcutaneous Tissue | Mass.gov
- Scar Revision: The use of InterQual provides guidance for the coverage of these additional Scar Revision procedures
- Evidence is also sufficient for coverage of Cosmetic and Reconstructive Surgery for Hemangioma, Port Wine Stain treatment, Hair Removal, Labiaplasty, and Liposuction for Lipedema. These procedures are identified in the medical literature and endorsed by various medical society guidelines.

The use of this supplemented criteria in the utilization management process will ensure access to evidence based clinically appropriate care. See References section below for all evidence accessed in the development of these criteria.

Clinical Guideline Coverage Criteria

The following are for Procedures with The Plan Medical Necessity Guidelines

• **General Reconstructive and Cosmetic Surgery**	**Coverage Guidelines**
	Reconstructive surgery and procedures are covered when the services are necessary to relieve pain or restore a bodily function that is impaired as a result of a congenital defect, birth abnormality, traumatic injury or covered surgical procedure. Prior authorization is required. For Massachusetts products only, consistent with Chapter 233 of the Acts

of 2016, reconstructive surgery and procedures to repair disturbances of body composition caused by HIV-associated lipodystrophy syndrome are covered when there is documentation from a treating provider that the treatment is necessary for correcting, repairing or ameliorating the effects of HIV-associated lipodystrophy syndrome[1]. Prior authorization is required.

In accordance with the federal Women's Health and Cancer Rights Act of 1998 (WHCRA)[2] and applicable state regulations, breast reconstructive procedures after mastectomy are covered for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance

Limitations

- Reconstructive surgery may not be covered for a congenital defect or birth anomalies that have not resulted in significant functional impairment.
- Cosmetic surgery or procedures are not covered at any time. Cosmetic means to change or improve appearance.

Code

HIV-associated lipodystrophy syndrome CPT codes:

Code	Description
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

ICD-10 CM Codes:

Code	Description
B20	Human immunodeficiency virus [HIV] disease
E88.1	Lipodystrophy, not elsewhere classified

- **Redundant Skin – Surgical Removal (includes Panniculectomy)**

Redundant skin is defined as large skin folds that are the result of a massive weight loss. Redundant skin can be present on several parts of the body. A pannus is an overhanging apron of redundant, abdominal skin. Panniculectomy is the surgical removal of the pannus. Brachioplasty is the term used to describe the surgical removal of the redundant skin from the upper arms.

√*Procedures for which Tufts Together utilizes guidance from the Mass Health Guidelines for Medical Necessity Determination for Excision of Excessive Skin and Subcutaneous Tissue*

Coverage Guidelines

The Plan may authorize coverage for the surgical removal of redundant skin if the Member meets **ONE** of the following criteria: (Documentation, including a letter of medical necessity is required)

1. Skin necrosis, recalcitrant to conventional wound healing interventions such as debridement; **or**
2. Recurrent skin infections refractory to medical treatment (e.g., requiring dressing changes; topical, oral, or systemic antibiotics, corticosteroids, or systemic antifungals)
    a. Recurrent to be defined as at least two incidences in a 12-month period; **or**
3. Intertriginous skin rashes or skin ulcerations that show no signs of healing after at least 8 weeks of care under the direction of a Dermatology or Wound Care Specialist.

    (Note: Submission of the Medical Record Documentation is required that indicates the nature of skin condition, treatments attempted and response to treatment)

Additional Coverage Guidelines

In cases where the redundant skin is the result of a medical weight loss,

	the weight loss must have been maintained for at least six months before the Member will be considered for a procedure based on the above criteria. In cases where the redundant skin is the result of bariatric surgery, The Plan will not cover the procedure until eighteen (18) months after the bariatric surgery is performed, the weight loss has been maintained for at least six (6) months and no more than an additional twenty (20) pound weight loss is anticipated before the Member will be considered for a procedure based on the above criteria. **Limitations** The Plan will not cover a request for redundant skin removal if it is for any **One** of the following reasons as it is not considered medically necessary to do so: 1. An abdominoplasty or panniculectomy for: a. Treatment of neck or back pain b. Repair of an abdominal laxity or diastasis recti c. Treatment of psychological or psychosocial issue related to redundant skin d. When the procedure is performed at the time of an additional abdominal or gynecological surgery unless it meets the medical necessity guidelines above 2. Abdominoplasty is considered cosmetic and therefore not medically necessary 3. Brachioplasty or thighplasty, etc.* 4. The Plan will not cover the surgical removal of redundant skin or body contouring for cosmetic purposes only. **Codes** The following CPT codes require prior authorization:

Code	Description
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
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

• **Liposuction for Lipedema**	**Coverage Guidelines** The Plan may authorize coverage for suction assisted lipectomy for the treatment of lipedema if the Member meets **ALL** of the following criteria: (Documentation, including a letter of medical necessity is required) 1. The Member has been diagnosed with lipedema and **All** of the following clinical findings are present: a. Tendency to bruise easily in lipedema-affected areas without apparent cause; **and** b. Absence of pitting edema; **and**

c. Pain or sensitivity to touch in in lipedema-affected areas; **and**
d. Negative Stemmer sign; **and**
e. Bilateral and symmetrical manifestation with minimal to no involvement of hands and feet; **and**
f. Disproportionate proliferation of fatty tissue on the limbs but not on the hands or feet (cuffing); **and**

2. Severe physical functional impairment (i.e. difficulty ambulating or performing activities of daily living); **and**
3. The Member has not had improvement to at least 6 months of consecutive conservative treatment (compression or manual therapy); **and**
4. For Members with moderate to high-risk obesity >35 kg/m, failure of the limb adipose hypertrophy to respond to recommended bariatric surgery or other medically supervised weight loss treatments; **and**
5. Documentation from both a referring medical provider and the surgeon performing the procedure that confirms the Member's severe functional impairment is a result of the lipedema and there is the expectation that treatment will restore the Member's function.
   Note:
   *When the Member requires more than one procedure from the same region of the extremity, documentation is required showing the liposuction volume is in excess of the generally clinically acceptable amount for a single surgery (e.g., greater than 5,000 ml total aspirate)

   Staged procedures with liposuction combined with excess skin removal that have the potential to change or improve appearance without significantly improving physiological function are considered cosmetic in nature and may be excluded from coverage. Requests for excess skin removal need to be reviewed against the Redundant Skin criteria in this medical necessity guideline.

   - For lymphedema surgery, refer to medical necessity guideline for Surgical treatments of Lymphedema
   - For gender affirming services, refer to medical necessity guideline for Gender Affirming Services
   - For HIV-associated lipodystrophy syndrome, see criteria above in Section General Reconstructive and Cosmetic Surgery.

Limitations

The Plan will not cover a request for lipedema surgery for **One** of the following reasons as it is not considered medically necessary:

1. For use in the trunk and back areas.
2. For use in head and neck areas.
3. Re-treatment of a previously treated area unless the anticipated total aspirate volume to be removed is in excess of generally clinically acceptable amount*

Codes

The following CPT codes require prior authorization:

Code	Description
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

- **Hemangioma, Port Wine Stain and other Cutaneous Vascular lesions**

Hemangioma is a blood-filled birthmark or benign tumor consisting of closely packed small blood vessels. Commonly found during infancy, it first grows and then may spontaneously disappear in early childhood without treatment.

Nevus flammeus, also known as a port wine stain, is a flat capillary hemangioma that is present at birth and that varies from pale red to deep reddish purple. These lesions most often occur on the face. The depth of the color depends on whether the superficial, middle, or deep dermal vessels are involved. On the face the lesion persists and develops a thick, verrucous, nodular surface.

Coverage Guidelines

Laser treatment for port wine stains, hemangiomas, and other proliferative vascular lesions are considered medically necessary when **ONE** of the following is met:

1. Lesion is visible on the face, ears, and/or neck; **or**
2. Port wine stains on the trunk and extremities when associated with recurrent bleeding, infection, pain or ulceration or when there is documented evidence of physical functional impairment; **or**
3. Hemangioma is associated with Kasabach-Merrit Syndrome; **or**
4. Hemangioma or other vascular malformation (e.g., venous, arteriovenous, lymphatic) and **ONE** of the following indications:
   a. Lesion compromises the function of vital structures, (e.g., nose, eyes, ears, vocal cord, lips); **or**
   b. Symptomatic lesion (e.g., bleeding, painful, ulcerated, eating difficulty or swallowing, prior infection, or pedunculated)

Note: Initial authorization for pulsed laser treatment will be approved for up to 8 sessions. Approval for further sessions requires documentation demonstrating that the initial 8 sessions have provided at least mild (25%) improvement from baseline. A new or updated treatment plan must be submitted, detailing the objective evidence of improvement (e.g., reduction in lesion size, improvement in skin texture/color) and the specific number of additional sessions requested.

Codes

The following CPT codes require prior authorization:

Code	Description
17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq. cm
17107	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq. cm
17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq. cm

- **Hair Removal by Laser or Electrolysis**

Coverage Guidelines

The Plan may authorize coverage for hair removal with laser or electrolysis, by a board-certified dermatologist or treating licensed provider, when the Member meets **One** of the following criteria:

1. Planned gender affirming genital surgery; **or**
2. Gender affirming face and neck hair removal; **or**
3. Recurrent infected cyst, hair follicle infections, or after surgical treatment of pilonidal sinus disease to prevent reinfection.

Note: Prior authorization for planned genital gender affirming surgery must be in place in order for The Plan to review a request for hair removal. Refer to the Medical Necessity Guidelines for Gender Affirming Services for more information.

Authorization for hair removal from face and neck only may be medically necessary when the Member meets criteria outlined in the Medical Necessity Guidelines for Gender Affirming Services.

Limitations

The Plan will not cover the removal of hair for cosmetic purposes. Cosmetic means to change or improve appearance. Hair removal may be covered with diagnosis of gender dysphoria.

Codes

The following CPT codes require prior authorization:

Code	Description
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue {when specified as permanent hair removal by laser}

ICD-10 Codes	Description
F64-F64.9	Gender identity disorder
Z87.890	Personal history of sex reassignment

Note: The above ICD-10-CM codes are subject to state regulations as applicable for Tufts Health Together Plans.

- **Labiaplasty**

Coverage Guidelines

The Plan may authorize coverage for labiaplasty for a diagnosis of hypertrophy in Members aged 18 and older when there is documentation of **One** of the following:

- Interference in basic activities and/or functions; **or**
- Recurrent rashes or non-healing ulcers in the affected area, despite conservative topical treatment; **or**
- Dyspareunia

Limitations

The Plan will not cover labiaplasty for cosmetic purposes.

CODES

The following CPT code requires prior authorization when billed with one of the diagnosis codes listed below:

Code	Description
56620	Vulvectomy simple; partial

ICD-10 Codes	Description
N90.60	Unspecified hypertrophy of vulva

N90.61	Childhood asymmetric labium majus enlargement
N90.69	Other specified hypertrophy of vulva

- **Breast Reconstruction**

Applicable to Harvard Pilgrim Health Care Commercial Members ONLY

Coverage Guidelines

The Plan may authorize coverage for breast reconstruction when documentation confirms **One** of the following:

1. Member has undergone a medically necessary mastectomy or lumpectomy procedure
    a. Documentation confirms a diagnosis or history of breast cancer or prophylactic treatment for high-risk cancer
2. Surgical reconstruction required for Poland syndrome and **Both** of the following:
    a. Severe musculoskeletal chest wall defects (absent or underdeveloped pectoralis major and minor muscles; absence of upper costal cartilage); **and**
    b. Functional impairment (e.g. respiratory compromise, exercise intolerance, impaired muscle strength that impacts activities of daily living) secondary to Poland Syndrome.

Limitations

The Plan considers breast reconstruction as not medically necessary for all other conditions. In addition, The Plan does not cover:

1. Cosmetic procedures (e.g., mastopexy, correction of inverted nipple) that are not part of an authorized post-mastectomy breast reconstruction procedure

Codes

The following codes require prior authorization

CPT Code	Description
19316	Mastopexy
19325	Breast augmentation; with implant
19340	Insertion of breast implant on same day of mastectomy (i.e., immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
19355	Correction of inverted nipples
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
19361	Breast reconstruction; with latissimus dorsi flap
19364	Breast reconstruction; with free flap (e.g., fTRAM, DIEP, SIEA, GAP flap)
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap
19369	Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap
19380	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)

The following are for procedures that require an InterQual SmartSheet or Subset

A. Breast Implant Removal

- InterQual - **Breast Implant Removal**

[+]Procedures for which Tufts Health One Care utilizes guidance from the Centers for Medicare and Medicaid Services

Codes

The following CPT codes require prior authorization:

Code	Description
19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast

B. Gynecomastia: Surgical Correction by Mastectomy, Male

- InterQual **Reduction Mammoplasty Male**
- InterQual **Reduction Mammoplasty, Male (Adolescent)**

[+]Procedures for which Tufts Health One Care utilizes guidance from the Centers for Medicare and Medicaid Services

Codes

The following CPT codes require prior authorization:

Code	Description
19300	Mastectomy for gynecomastia

C. Reduction Mammoplasty for Macromastia Female

- InterQual SmartSheets, **Reduction Mammoplasty, Female**
- InterQual SmartSheet **Reduction Mammoplasty, Female (Adolescent)**

[+]Procedures for which Tufts Health One Care utilizes guidance from the Centers for Medicare and Medicaid Services

The Plan Modifications to InterQual

Criterion section **(20)** of the InterQual SmartSheet, for **'Breast reduction of contralateral breast post mastectomy'** does not require prior authorization.

Codes

The following CPT codes require prior authorization:

Code	Description
19318	Reduction mammoplasty

D. Rhinoplasty

- InterQual SmartSheet **Rhinoplasty**

⁺Procedures for which Tufts Health One Care utilizes guidance from the Centers for Medicare and Medicaid Services

×Procedures for which Tufts Together utilizes guidance from the Mass Health Guidelines for Rhinoplasty

Codes

The following CPT codes require prior authorization:

Code	Description
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)

Note: If rhinoplasty is being requested for the indication of gender reassignment, please refer to Medical Necessity Guidelines for Gender Affirming Services.

Note: For the diagnosis of cleft lip and/or cleft palate, the following CPT codes are covered **without** prior authorization:

Code	Description
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

E. Scar Revision

Note: Applicable to Tufts Health Plan Products **ONLY**

For Harvard Pilgrim Health Care Coverage please refer to the Removal of Benign Skin Lesions MNG

There are three InterQual SmartSheets that represent procedures for scar revision.
These are:

- **Scar Revision**
- **Scar Contracture Release**
- **Keloid Excision**

The Plan Modifications to InterQual

Criterion section **1(A)** of the InterQual SmartSheet **Scar Revision** for **'Mismatch of vertical edges'** does not meet the findings requirement because it is considered cosmetic.

The Plan may authorize Keloid Excision (fractional laser ablation) for Members less than 18 years of age when:

- InterQual criteria for the procedure is met

Limitations

The Plan will not cover scar revision done for cosmetic purposes, for example: only to alter the appearance of the scar.

Codes

The following CPT code(s) require prior authorization when performed with any of the ICD-10-CM codes listed below:

CPT Code	Description
0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants and children
0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq. cm or less
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm
11404	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm
11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet,

	genitalia; excised diameter 2.1 to 3.0 cm
11424	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm
11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
11440	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm
11443	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm
11444	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm
11446	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm
13102	Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm
13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
13151	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm
13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm

ICD-10-CM Code(s):

Code	Description
L90.5	Scar conditions and fibrosis of skin
L91.0	Hypertrophic scar

Limitations

The Plan considers the following cosmetic and reconstructive procedures as not medically necessary:

1. Chemical Peel (dermal and epidermal)
2. Dermabrasion
3. Injection of dermal filling materials for cosmetic purposes (e.g., treatment of acne or chicken pox scars, or facial wrinkles)
4. Microdermabrasion
5. Removal of skin tags
6. Removal of decorative tattoo
7. Shaving or removal of a benign, asymptomatic epidermal or dermal lesions
8. Treatments for acne scarring including (but not limited to) dermal fillers, surgery, cryotherapy, chemical exfoliation, and laser and light-based therapies (e.g., blue light therapy, pulsed light, diode laser treatment)

References:

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7. Faria AM, Valerio CM, Barcellos CR, et al. Unraveling lipedema: comprehensive insights and the path to future discoveries. *NPJ Metab Health Dis*. 2026;4(1):3. Published 2026 Jan 17. doi:10.1038/s44324-025-00093-y.
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Approval And Revision History

July 15, 2020: Reviewed by IMPAC and added language to section I.A: General Reconstructive and Cosmetic Surgery regarding WHCRA mandate. Clarified limitation to include seasonal variation under section I.C: Hemangioma and Port Wine Stain Treatments.

Subsequent endorsement date(s) and changes made:

- July 23, 2020: Fax number for Unify updated
- March 17, 2021: Reviewed by IMPAC, renewed without changes
- March 16, 2022: Reviewed by Medical Policy Approval Committee (MPAC) for integration purposes between Harvard Pilgrim Health Care and Tufts Health Plan for an effective date of March 16, 2022 for THP and January 1, 2023 for HPHC. Added hair removal for neck/face for gender affirming surgery; added IQ modification for gynecomastia and removed Pilonidal cyst limitation
- June 15, 2022: Reviewed by MPAC and removed stand-alone content for physical functional impairment under Section IB. Redundant Skin – Surgical Removal (includes Abdominoplasty /Panniculectomy), effective June 15, 2022.
- July 20, 2022: Review by MPAC and InterQual 2022 update approved effective 9/12/22; added language for Fractional laser ablation of burns and traumatic scars, see Keloid Excision IQ Smartsheet
- November 16, 2022: Reviewed by MPAC; criteria for keloid excision clarified; effective January 1, 2023
- June 21, 2023; Reviewed by MPAC; InterQual modifications removed for Gynecomastia; Added note for Mass Health Note for Tufts Health Together regarding coverage for Brachioplasty and Thighplasty Effective September 1, 2023
- October 18, 2023: Reviewed by MPAC, Added note for Tufts Health One Care regarding coverage for Brachioplasty and Thighplasty, renewed with no additional changes
- November 4, 2023: Coding updated to now require PA for Harvard Pilgrim Health Care for code 17380 effective February 1, 2024
- November 2023: Rebranded Unify to One Care and updated One Care criteria effective January 1, 2024
- December 1, 2023: Reviewed and approved by the UM committee effective July 1, 2024
- February 21, 2024: Reviewed by MPAC, added criteria for liposuction of lipedema and codes 15878, 15879 for PA effective April 1, 2024
- March 20, 2024: reviewed by MPAC, renewed without changes, effective May 1, 2024
- May 15, 2024: Reviewed by MPAC, note added to Liposuction for Lipedema section regarding staged procedures combined with excess skin removal effective July 1, 2024
    - Redundant Skin criteria updated to clarify that recurrent skin infections must be “refractory to medical treatment (e.g., requiring dressing changes, topical, oral, or systematic antibiotics, corticosteroids or systemic antifungals”; criteria updated to require the submission of medical records indicating the nature of skin condition, treatment, etc. Harvard Pilgrim Commercial will review requests for panniculectomy/redundant skin through the standard UM process without InterQual effective September 1, 2024
    - Reviewed for 2024 InterQual Upgrade effective September 1, 2024
    - Codes 15830, 15834, 15835, 15837, 15838, and 55620 will require PA for Tufts Health Direct, Tufts Health Together, and One Care effective September 1, 2024
    - Codes 11042, 0479T, and 0480T will require PA only when submitted with ICD-10 code L90.5 and L91.0 for Tufts Health Direct, Tufts Health Together, Tufts Health RITogether, and One Care effective September 1, 2024
- June 13, 2024: Reviewed and approved by the UM Committee, effective July 1, 2024
- October 17, 2024: Reviewed by MPAC, added 19380 to Breast Reconstruction section for HPHC Commercial only effective January 1, 2025
- February 19, 2025: Reviewed by MPAC, For rhinoplasty procedure moving from InterQual criteria to using Mass Health Guidelines for Tufts Health, effective April 1, 2025
- April 16, 2025: Reviewed by MPAC, renewed without changes effective May 16, 2025
- May 21, 2025: Reviewed by MPAC for 2025 InterQual Update effective July 1, 2025
- May 20, 2026: Reviewed by MPAC for 2026 InterQual Update; administrative update to guideline template, and changed visit limit of 6 for laser treatment of *Hemangioma, and Port Wine Stain and other Vascular lesions* to allow for 6-8 visits and additional visits will require documentation of medical necessity, effective July 1, 2026
- June 17, 2026: Reviewed by MPAC for annual review; added criteria for Polland syndrome under Breast Reconstruction section and added code 19325, effective August 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of The Plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.