

Policy Key: Cosmetic and Reconstructive Procedures

TriWest Clinical Operations – TRICARE West

SCOPE

This Policy Key provides criteria to be used during medical necessity review of covered cosmetic, reconstructive, and plastic surgery procedures.

Note: Panniculectomy should be sent to Second Level Review to determine medical necessity.

NOT COVERED [1,2,3,7]

When it is determined that a cosmetic, reconstructive and/or plastic surgery procedure does not qualify for benefits, all related services and supplies are excluded, including any institutional costs. This includes the following:

- Dental congenital anomalies such as absent tooth buds or malocclusion
- Cosmetic, reconstructive, and/or plastic surgery procedures performed primarily for psychological or psychiatric reasons or as a result of the aging process
- Procedures performed for elective correction of minor dermatological blemishes and marks or minor anatomical anomalies
- Any procedure performed for personal reasons to improve the appearance of an obvious feature or a body part that would be considered by an average observer to be normal and acceptable for the patient's age and/or ethnic and/or racial background
- Face lifts, chemical peels, and other procedures related to the aging process
- Panniculectomies primarily performed for body sculpture procedures/reasons of cosmesis (unless it is medically necessary)
- Blepharoplasty, except when performed for correction of documented significant impairment of vision
- Rhinoplasties, except when performed to correct a bodily function. Septoplasty is covered when performed to correct airway obstruction
- Otoplasty for protruding and/or prominent ears. Otoplasty for microtia, lop ear, constricted ear, and other congenital ear deformities may be covered.
- Chemical peeling (exfoliation) for any of the following:
 - Aging skin
 - Removal of facial wrinkles
 - Treatment of acne
 - Acne scars
- Revision of scars resulting from surgery and/or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery

- Facial dermabrasion, except when performed as part of surgery to restore body form following an accidental injury or revision of disfiguring and extensive scars resulting from neoplastic surgery
- Removal of tattoos
- Hair transplants
- Electrolysis or laser hair removal
- Cosmetic procedures performed as part of gender-affirming surgery
- Body contouring
- Rhytidectomy **except** for treatment of facial palsy or significant facial burns or other significant major facial trauma
- Facial implants **except** when performed as part of surgery to restore body form following an accidental injury or revision of disfiguring and extensive scars resulting from neoplastic surgery
- Face transplant, maxillary transplant, and facial Composite Tissue Allotransplantation (CTA)
- All services and supplies directly and indirectly related to surgical treatment (i.e., gender change), except when performed to correct ambiguous genitalia which was documented to have been present at birth [6]
- Reduction mammoplasty solely to treat fibrocystic breast disease [10]
- Reduction mammoplasty sole for cosmetic reasons [10]
- All services and supplies directly and indirectly related to sex gender change and intersex surgery, except when performed to correct ambiguous genitalia [7]

COVERAGE CRITERIA

General Information

Benefits may be allowed for cosmetic, reconstructive, and/or plastic surgery, including otherwise covered services and supplies, for congenital anomalies and the conditions/indications listed under the coverage criteria. [1]

- Benefits are limited to those cosmetic, reconstructive, and/or plastic surgery procedures performed no later than December 31 of the year following the year in which the related accidental injury or surgical trauma occurred.
 - There is an exception for authorized postmastectomy reconstructive breast surgery for which there is no time limitation between mastectomy and reconstruction.
 - Special consideration will be given to cases involving children who may require a growth period.

Blepharoplasty [1,13]

Initial Level of Review may approve **ANY** of the following:

- When performed to remove excess upper lid tissue to correct significant impairment of vision when **ALL** the following are met
 - Photographs taken within the past 12 months in straight gaze show redundant eyelid tissue overhanging the upper eyelid margin or resting on or pushing down on the eye lashes.

- Documentation of visual field testing within the past 12 months that is performed with and without the eyelid or brow taped show **both** of the following:
 - A superior visual field of 30 degrees or less before taping **AND**
 - Either of the following:
 - An increase in superior visual fields of 12 degrees or more
 - A 30 percent or greater increase in superior visual fields
- To correct prosthesis difficulties in an anophthalmia socket of the upper and or lower lids
- To relieve painful symptoms of upper lid blepharospasm
- To treat peri-orbital sequelae of thyroid disease and nerve palsy, and periorbital sequelae of other upper lid nerve palsy (e.g., the oculomotor nerve)
- To relieve excessive lower lid bulk only if proper positioning of prescription eyeglasses is precluded and is secondary to conditions such as chronic systemic corticosteroid therapy, dermatomyositis, Grave's disease, myxedema, nephrotic syndrome, polymyositis, scleroderma, Sjogren's syndrome, and systemic lupus

Note: with unilateral disease meeting criteria for the above-listed procedures, contralateral eye surgery may be considered medically necessary to obtain symmetry.

Correction of Ambiguous Genitalia [6,7,8]

Note: Documentation that ambiguous genitalia was present at birth this required for all treatment for **ANY** of the following.

- Surgery to treat ambiguous genitalia, including sex gender change and intersex surgery
- Insertion of FDA approved penile or testicular implants

Liposuction [1,9]

Initial Level of Review may approve when all the following are met:

- Diagnosis of Stage I, II, or III Lipedema
- Age 18 years or older
- BMI < 30
 - Documented pain and tenderness in the affected areas or bodily function impairment (e.g., walking, skin integrity) and the liposuction will significantly contribute to the safe and effective correction of improvement of the bodily function
 - Symptoms unresponsive to at least six consecutive months of adherence to conservative methods, such as Complete Decongestive Therapy (CDT), compression, or weight loss
 - Procedure is performed by an authorized surgeon trained in liposuctions/body contouring and the following published medical guidelines for safe lipoaspirate volumes based on body weight.
 - When used as a substitute for the scalpel is covered when medically necessary, appropriate, and meets the standard of care.

Otoplasty [1]

Initial Level of Review may approve for congenital ear deformities such as microtia, lop ear, constricted ear, or other congenital ear deformities

Pectus Excavatum Surgery [1]

Initial Level of Review may approve for correction of a congenital anomaly when the defect is more than a minor anatomical anomaly

Restoration of Body Form (including revision of scars)

- Following accidental injury
- Revision of disfiguring and extensive scars from neoplastic surgery
- Facial dermabrasion
 - When performed as part of surgery to restore body form following an accidental injury or revision of disfiguring and extensive scars resulting from neoplastic surgery)
- Facial implants when performed as part of surgery to restore body form following an accidental injury or revision of disfiguring and extensive scars resulting from neoplastic surgery.

Rhinoplasty [1]

Initial Level of Review may approve when performed to correct a bodily function.

Rhytidectomy [1]

Initial Level of Review may approve for treatment of facial palsy, significant facial burns, or other significant major facial trauma

Skin Tags

Initial Level of Review may approve removal of a skin tag when at least one of the following criteria is met [15]:

- The skin tag becomes recurrently irritated or bleeds, particularly due to friction from clothing, equipment, or routine activities.
- The skin tag is located on the eyelid and interferes with vision or eyelid function.
- The skin tag causes significant or sudden-onset pain, suggesting possible inflammation, torsion, or other underlying pathology.

NOTE: Refer to FLR Denial Verbiage when none of the ILR criteria are met.

Stab Phlebectomies for Varicose Veins (37799) [10]

Initial Level of Review may approve when the following criteria are met [15]:

- Documented diagnosis of varicose veins, **AND**
- Procedure is performed on **<10 veins per session, AND**
- Meets policy criteria for coverage of endovascular ablation for varicose veins.

FLR Approval Verbiage:

TRICARE Policy Manual Chapter 4, Section 9.1 (Cardiovascular System), states that laser endovenous ablation is a covered benefit for patients with persistent symptoms interfering with



activities of daily living, in spite of conservative/non-surgical management. Stab phlebectomies are covered treatments of varicose veins.

Coding review has confirmed the code is correct. Approved.

DEFINITIONS

Cosmetic, reconstructive, and/or plastic surgery is defined as surgery or treatments (including procedures, drugs, and devices) that can be expected to primarily improve the physical appearance of a beneficiary, and/or is performed primarily for psychological purposes, and/or restores form, but does not correct or materially improve a bodily function. [1]

Congenital anomaly is defined as a condition existing at or from birth that is considered a significant deviation from the common form or norm and is other than a common racial or ethnic feature. Two examples of congenital anomalies are cleft lip and syndactyly. Congenital anomalies do not include anomalies relating to teeth (including malocclusion or missing tooth buds) or structures supporting the teeth, or to any form of sex gender confusion (see 32 CFR 199.2(b) for full definition of congenital anomaly). [1]

CODES

CPT 55970, 55980

REFERENCES

[1] TRICARE Policy Manual 6010.63-M, April 2021, Change 17 (September 20, 2024) Chapter 4, Section 2.1, Cosmetic, Reconstructive, and Plastic Surgery - General Guidelines, https://manuals.health.mil/pages/DisplayManualHtmlFile/2024-09-20/AsOf/TPT5/C4S2_1.html

[2] TRICARE Policy Manual 6010.63-M, April 2021, Change 17 (September 20, 2024) Chapter 4, Section 5.2, Post-Mastectomy Reconstructive Breast Surgery and Breast Prostheses, https://manuals.health.mil/pages/DisplayManualHtmlFile/2024-09-20/AsOf/TPT5/C4S5_2.html

[3] TRICARE Policy Manual 6010.63-M, April 2021, Change 17 (September 20, 2024) Chapter 4, Section 5.3, Post-Prophylactic Mastectomy, Prophylactic Oophorectomy, and Prophylactic Hysterectomy, https://manuals.health.mil/pages/DisplayManualHtmlFile/2024-09-20/AsOf/TPT5/C4S5_3.html

[6] TRICARE Policy Manual 6010.63-M, April 2021, Change 17 (September 20, 2024) Chapter 4, Section 16.1, Intersex Surgery, https://manuals.health.mil/pages/DisplayManualHtmlFile/2024-09-20/AsOf/TPT5/C4S16_1.html

[7] TRICARE Policy Manual 6010.63-M, April 2021, Change 17 (September 20, 2024) Chapter 4, Section 15.1, Male Genital System, https://manuals.health.mil/pages/DisplayManualHtmlFile/2024-09-20/AsOf/TPT5/C4S15_1.html

[8] TRICARE Policy Manual 6010.63-M, April 2021, Change 17 (September 20, 2024) Chapter 4, Section 17.1, Female Genital System, https://manuals.health.mil/pages/DisplayManualHtmlFile/2024-09-20/AsOf/TPT5/C4S17_1.html



[9] TRICARE Policy Manual 6010.63-M, April 2021, Change 17 (September 20, 2024) Chapter 1, Section 6.1, Special Authorization Requirements, https://manuals.health.mil/pages/DisplayManualHtmlFile/2024-09-20/AsOf/TPT5/C1S6_1.html

[10] TRICARE Policy Manual 6010.63-M, Chapter 4, Section 9.1: Cardiovascular System. Retrieved August 27, 2025. https://manuals.health.mil/pages/DisplayManualHtmlFile/2025-01-08/AsOf/TPT5/c4s9_1.html

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