Pediatric Care Network
Precertification Guidelines

Subject: Cosmetic Procedures
Applies to: Missouri and Kansas Membership
Purpose: This guideline provides a framework for the process of determining when a procedure or event is considered cosmetic.

Effective date: February 1, 2012
Revision(s): March 31, 2014; April 6, 2015; April 11, 2016; March 28, 2017; April 25, 2018; May 14, 2019; May 5, 2020; February 12, 2021; September 29, 2022; August 20, 2023; August 20, 2024; August 20, 2025

Policy:

- **Statement of coverage decision:** cosmetic procedures are not a covered benefit for any population. The determination of what is done to improve appearance alone versus correct a functional concern requires a medical determination, and therefore requires Prior Authorization. Providers can access prior authorization requirements on the resource page of the PCN website at https://www.cmics.org/pcn/Home/Resources. Specifically noted procedures are: scar revision, varicose vein procedure, skin tags, breast surgery (not related to cancer diagnosis), obesity related procedures, and otoplasty. Any medically necessary procedure which could ever be considered cosmetic in nature must be prior authorized.
- **Criteria for coverage:** The following list is not intended to be exhaustive or complete. It serves to illustrate how a procedure may or may not be considered cosmetic. Several procedures and conditions are mentioned specifically to give clearer guidance when similar conditions, which are not explicitly mentioned, occur.
    - Any one of the following are considered cosmetic procedures:
        - Augmentation mammoplasty other than for breast reconstruction due to a cancer diagnosis – see discussion below re: congenitally absent breast.
        - Circumcision beyond the newborn period, unless one of the following is present: phimosis, penile lichen sclerosis, posthitis, balanitis, recurrent urinary tract infection, vesicoureteral reflux, or traumatic injury to the foreskin.
            - Newborn Period will be defined as within the first 28 days of life and is extended to include within 6 months of discharge from the NICU and/or when there have been delays for prematurity or other congenital abnormalities.
            - All requests for Circumcision outside of the newborn period as defined above will be reviewed against Milliman Guideline ACG: A-0269
        - Dermabrasion or chemical peel, unless for the treatment of a malignant or premalignant lesion. Treatment of acne or acne scars or benign facial pigment is cosmetic.
        - Electrolysis or laser hair removal.
        - Excision of excessive skin, such as arms, thighs, chins.
            - Exception is a panniculectomy or blepharoplasty that is reviewed against and meets Milliman Guideline A-0195
        - Gender change surgery including but not limited to mastectomy, penile construction, vaginoplasty, labioplasty and release of vaginal adhesions.
        - Hair transplant
        - Keloids that are large but not tender (not requiring regular use of medication) or infected (not requiring antibiotic treatment).
        - Labioplasty, Vaginoplasty or other vaginal rejuvenation procedures
        - Lipectomy, liposuction
        - Otoplasty for ear abnormalities such as a cup or lop ear (no folds in the outer ear) with no functional decrease in hearing.
        - Procedures or medications to treat complications of a cosmetic procedure.
            - This includes, but is not limited to, keloids or tears from body piercing
        - Removal of spider angioma, unless documented bleeding has occurred.
        - Tattoo removal
        - Telangiectasia treatment with laser or sclerotherapy in asymptomatic patients
        - Any other procedure that is designed to enhance appearance that does not correct a functional defect.

- The following conditions are considered medically necessary when Milliman, or other applicable criteria are met, with appropriate medical records and photographs, and prior approval process followed:
  - Augmentation mammoplasty for congenital absence of breast. Augmentation mammoplasty is typically a cosmetic procedure except in the reconstruction after breast cancer treatment or when associated with congenital absence of the breast (such as Poland syndrome). Augmentation for asymmetric breast development is considered cosmetic.
  - Breast reconstruction related to a diagnosis of breast cancer. This includes surgical procedures on the affected breast including nipple tatooing, and reduction and/or mastopexy on the contralateral breast.
    - PCN will review against most appropriate Milliman Guidelines (several may be applicable).
    - For this procedure, prevention of cancer mastectomy (prophylactic mastectomy) is considered medically necessary when Milliman Guidelines (S-860) is met and would also be approved for reconstruction.
  - Congenital facial abnormalities reconstruction, such as a mid-face deformity that would be classified as a major congenital defect are considered reconstructive surgery.
  - Gynecomastia – follow Milliman Guidelines, A-0273.
  - Otoplasty for micro-otia where the deformity affects hearing by impacting the ear canal and creating a conductive hearing loss.
  - Pectus Carinatum treatment, one of the following:
    - Bracing for moderate to severe cases with any of the following:
      - Chest pain
      - Chest wall tenderness
      - Exercise limitations
      - Palpitations
      - Shortness of breath
      - Wheezing
    - Surgical repair for patients with any of the above symptoms and one of the following:
      - Initial approach for patients who are skeletally mature
      - Secondary approach for patients who have entered their pubertal growth spurt and who have not received adequate results from bracing
  - Pectus Excavatum surgical repair when all the following:
    - Complications from the sternal compression, one required:
      - Cardiac compression, displacement, mitral valve prolapse, murmurs or conduction abnormalities
      - Pulmonary function testing shows restrictive respiratory disease
      - Failed previous repair of pectus excavatum
    - CT of the chest has a Haller index of more than 3.25 (transverse diameter divided by the A-P diameter), which indicates moderate to severe Pectus Excavatum.
  - Port wine stains or hemagiomas - Excision and/or pulsed-dye laser treatment of port wine stains and other hemangiomas is considered medically necessary when lesions are located on the face and neck. Typical resolution patterns would be considered on the need to intervene for any hemagiomas requests. Treatment of other body areas requires bleeding or infection or other medical symptoms to be considered medically necessary.
  - Prosthesis: eye, ear, face, nose, breast, and testicular prosthesis are all covered when replacing a body part either congenitally absent or lost due to disease, injury or surgery. This may not always restore function, but the loss of these organs or body areas are a significant defect that requires correction if possible. This includes spacer prosthetic to allow the eye socket to continue development in the case of micro-ophthalmia or excision.

  - Reduction mammoplasty – must be a covered benefit by the State and meet Milliman Guideline A-0274.
  - Removal of congenital nevi - approved to prevent risk of malignant transformation.
  - Rhinoplasty - when meets Milliman Guideline A-0184.
  - Scar revision – when meets Milliman Guideline A-0495
  - Skin tag removal – medically necessary when located in an area of friction, with documentation of repeated (more than twice) bleeding and irritation.
    - Would not include facial or neck skin tags. Irritation from jewelry would be an elective (cosmetic) need for removal.
    - Area of friction would be underwear or waist area, inner thigh.
    - Preauricular ear appendage removal. Approved as medically necessary as a congenital anomaly but require prior approval since the code for removal is the same as for other skin tags.
- **Authorization period:** per precert procedures
- **Discontinuation of authorization:** N/A
- **Reasons for non-coverage:** cosmetic procedures are not covered based on description of non-covered services from State manuals. The above is not intended to be an exhaustive list. The basic guideline of improving form but not correcting any functional deficiency assists in the determination of cosmetic procedures not otherwise listed above.
- Codes that are listed as not covered on the Missouri or Kansas state fee schedules will be reviewed for EPSDT exception as applicable by PCN Medical Director.
- **Medical background:**
  Medical need is the basis for care and procedures provided to our members. Traditionally cosmetic procedures are not a covered benefit by medical insurance, including Missouri and Kansas Medicaid plans. The MHD Physician Manual states the following is non-covered "cosmetic surgery directed at improving appearance (e.g., augmented mammoplasty, face lifts, rhinoplasty, etc.)" Similarly, the Kansas Medical Assistance Program Hospital Provider Manual states, "All surgeries which are cosmetic in nature (and related complications) are not covered."
  Cosmetic surgery in its simplest definition is designed to improve form not function. It is intended to reshape a body area to conform to that individual's perception of how he or she would like to appear. The body area may be within the expected appearance for ethnicity, genetics, age and gender, but not be satisfactory to the person. Reconstructive surgery, which may result in a change in appearance, is done primarily to improve bodily function. Major birth defects or congenital abnormalities are usually considered appropriate for reconstructive surgery. Based on the Centers for Disease Control and Prevention (www.cdc.gov) definition, major birth defects are conditions that cause structural changes in one or more parts of the body; are present at birth; and have a serious, adverse effect on health, development, or functional ability. Examples would be cleft lip/palate, clubfoot, syndactyly, or limb reductions. Minor anomalies do not typically require reconstructive surgery, because they do not impact function, and are a slight variation in bodily form. Examples would be clinodactyly, supranumerary nipples, or preauricular pits. There is also a wide range of appearance in body habitus and facial features that are familial. Our intent is to approve reconstruction designed to address significant congenital defects or major birth defects, or tissue or organ damage from injury or disease. Correction of minor physical anomalies or familial body or facial features is beyond the realm of medical need and would be considered an elective correction of appearance.

Definitions:

- Cosmetic plastic surgery includes surgical and nonsurgical procedures that enhance and reshape structures of the body to improve appearance and confidence. (American Society of Plastic Surgeons definition)
- Cosmetic Surgery – directed at improving appearance (Missouri HealthNet Division Physician Manual)
- Hirsutism - excessive male-pattern hair growth
- Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve functions but may also be done to approximate a normal appearance. (American Society of Plastic Surgery)

- Orthotic or brace – a DME device to mechanically compensate for a weakened body part or area or corrects a function of an intact body part.
- Prosthetic – a DME device to replace an absent or deformed body part or area to restore function. The most common example would be a limb prosthesis following an amputation.

References:

- American Society of Plastic Surgeons web site, www.plasticsurgery.org, accessed September 2025
- Centers for Disease Control and Prevention web site, www.cdc.gov, section on Birth Defects, accessed September 2025
- Kelly RE Jr., "Pectus excavatum: historical background, clinical picture, preoperative evaluation and criteria for operation," Seminars in Pediatric Surgery, 2008 Aug;17(3):181-93.
- Kelly RE Jr, Cash TF, Shamberger RC, et al, "Surgical repair of pectus excavatum markedly improves body image and perceived ability for physical activity: Multicenter study," Pediatrics. 2008;122(6):1218-1222.
- Khanna G, Jaju A, Don S, Keys T, Hildebolt CF, "Comparison of Haller index values calculated with chest radiographs versus CT for pectus excavatum evaluation," Pediatric Radiology. 2010 Nov;40(11):1763-7.
- Mayo Clinic website, https://www.mayoclinic.org/tests-procedures/cosmetic-surgery/about/pac-20385138 September 2025
- MedlinePlus, https://medlineplus.gov/plasticandcosmeticsurgery.html, health topic Plastic and Cosmetic Surgery, accessed September 2025
- Milliman Care Guidelines, 29th Edition, (2025 retrieved from: https://careweb.careguidelines.com/ed29/index.html
- UpToDate®, "Pectus Carinatum: Treatment," https://www.uptodate.com/contents/pectus-carinatum-and-arcuatum, accessed September 2025
- UpToDate®, "Pectus Excavatum: Treatment," https://www.uptodate.com/contents/pectus-excavatum-treatment, accessed September 2025
- UpToDate®, "Laser and light therapy of lower extremity telangiectasias, reticular veins and small varicose veins," https://www.uptodate.com/contents/laser-and-light-therapy-of-lower-extremity-telangiectasias-reticular-veins-and-small-varicose-veins, accessed September 2025
- UpToDate®, "Management of hirsutism in premenopausal women," https://www.uptodate.com/contents/management-of-hirsutism-in-premenopausal-women, accessed September 2025
- UpToDate®, "Congenital anomalies of the ear," https://www.uptodate.com/contents/congenital-anomalies-of-the-ear, accessed September 2025

Regulatory references:

- State of Missouri MO Healthnet Manuals (2024). *Ambulatory Surgical Center Manuals, Non-Covered Services Section.* Retrieved from https://mydss.mo.gov/mhd/provider-manuals .
- State of Missouri MO Healthnet Manuals (2025). *Physician and, Hospital Manuals, Non-Covered Services Section.* Retrieved from https://mydss.mo.gov/mhd/provider-manuals .
- Kansas Medical Assistance Program (2025). *Hospital Provider Manual, Surgery-Cosmetic Section*. Retrieved from https://portal.kmap-state-ks.us/PublicPage/Public/ProviderManuals

Policy drafted by: PCN Medical Management Committee

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Disclaimer: Any coverage determination requires medical necessity, coverage by the member's benefit plan, and eligibility. The sole purpose of this document is to address medical necessity.