AmeriHealth Caritas Ohio

Cosmetic and Reconstructive Surgery

Reimbursement Policy ID: RPC.0141.7700

Recent review date: 09/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

The policy describes reimbursement of claims for cosmetic procedures and reconstructive surgery.

Exceptions

N/A

Reimbursement Guidelines

Cosmetic Procedures
Cosmetic Procedures are services performed primarily to improve physical appearance and are generally not covered unless they are determined to be medically necessary.

Procedures that are cosmetic in nature may be considered for coverage only when determined to be medically necessary, such as reconstruction following illness, injury, or disease. Prior authorization is required unless otherwise specified by the member's benefit plan.

Reconstructive Surgery
Reconstructive surgery may be covered when medically necessary to restore or improve the function of a physical impairment resulting from illness, injury, or congenital anomaly.

Breast Reconstruction Following Mastectomy
Breast reconstruction following mastectomy for breast cancer is covered with authorization, in accordance with applicable benefit plans. Covered services may include:

- Reconstruction of the affected breast
- Surgery to achieve symmetry of the contralateral breast
- Breast prostheses
- Treatment of complications related to mastectomy

Blepharoplasty
Blepharoplasty is covered when medically necessary and supported by clinical documentation demonstrating functional impairment (e.g., visual obstruction). Prior authorization is required.

Definitions

Cosmetic procedures
Cosmetic procedures are elective, aesthetic treatment designed to enhance, reshape, or alter body parts to improve appearance and boost self-confidence.

Reconstructive Surgery
Surgery or other procedures which are related to an injury, sickness, or congenital anomaly.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. Corresponding Clinical Policies.
III. Applicable manual reference.
IV. Applicable Ohio Medicaid Fee Schedule(s).
V. Ohio Administrative code rule 5160-2-03

Attachments

N/A

Associated Policies

CCP.1184 Cosmetic surgery: plastic reconstructive surgery

Policy History

09/2026	Reimbursement Policy Committee Approval