

PHP_7.08		Reconstructive Services	
Original Policy Date:	December 1, 2025	Effective Date:	June 1, 2026
Section:	7.0 Surgery	Page:	Page 1 of 11

State Guidelines

Applicable Medi-Cal guidelines as of the publication of this policy (**this guideline supersedes the criteria in the Policy Statement section below**):

- I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline:
 - N/A

- II. Department of Health Care Services (DHCS) Provider Manual Guideline:
 - [TAR and Non-Standard Benefits List: Codes 10000 thru 19999 \(tar and non cd1\)](#)
 - [TAR and Non-Standard Benefits List: Codes 20000 thru 29999 \(tar and non cd2\)](#)
 - [TAR and Non-Standard Benefits List: Codes 30000 thru 39999 \(tar and non cd3\)](#)
 - [TAR and Non-Standard Benefits List: Codes 50000 thru 59999 \(tar and non cd5\)](#)
 - [Local Educational Agency \(LEA\) Service: Speech Therapy \(loc ed serv spe\)](#)
 - [TAR and Non-Standard Benefits List: Codes G0000 thru G9999 \(tar and non cdg\)](#)
 - [TAR and Non-Standard Benefits List: Codes H0000 thru J9999 \(tar and non cdhj\)](#)
 - [TAR and Non-Standard Benefits List: Codes Q0000 thru Q9999 \(tar and non cdq\)](#)

The codes listed on the policy are included in the above Provider Manuals; however, there are no specific clinical guidelines.

- III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline:
 - N/A

NOTE: Refer to [Appendix A](#) to see the state guidelines/policy statement changes (if any) from the previous version.

Policy Statement

Any criteria that are not specifically addressed in the above Provider Manuals, please refer to the criteria below.

- I. In interpreting whether a proposed procedure meets the definition of reconstructive surgery, as defined by law, the procedure may be denied as **not medically necessary** under **any** of the following conditions:
 - A. The procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by providers specializing in reconstructive surgery
 - B. The treating surgeon cannot or will not provide sufficient documentation, including (when appropriate) medical quality color photographs, which accurately depicts the extent of the clinical problem (see [Policy Guidelines](#) and [Documentation for Clinical Review](#) sections)
 - C. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes

- D. The procedure is for [cosmetic](#) purposes only
- II. The use of silicone type injectables (e.g., Sculptra) to treat HIV-related lipoatrophy when it is likely that the injection(s) will result in more than minimal improvement in appearance may be considered **medically necessary**.

Policy Guidelines

Cosmetic surgery is distinguished from reconstructive surgery. "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

Only a licensed provider (e.g., physician, podiatrist, or oral and maxillofacial surgeon) who is competent to evaluate the specific clinical issues involved in the care requested may deny initial requests for authorization of coverage.

For the purpose of this policy, the qualified reviewer will differentiate a normal structure from an abnormal one based on **any** of the following elements:

- The availability of published normative data for specific anatomic measurements (e.g., cephalometric data for orthognathic surgery)
- The normal structural changes that are accommodative responses to gain or loss of body mass. Note that procedures to address excess skin in the setting of prior significant weight loss due to treatment of obesity qualify as reconstructive surgery if, on medical review of the requests, they meet the criteria of the California Reconstructive Surgery Act. (See Medical Policy for Panniculectomy, Abdominoplasty, and Surgical Management of Diastasis Recti.)
- The normal structural changes that are associated with aging (e.g., breast ptosis)
- The normal structures wide range of accepted variations in diverse populations (e.g., nasal size and shape)
- The presence of a cosmetic implant, in the absence of adjacent native tissue structural pathology, does not constitute an abnormal structure (e.g., cosmetic unilateral, bilateral or asymmetrical saline breast implants)

In determining whether or not a procedure is likely to result in more than minimal improvement in appearance, the qualified reviewer will consider both the size and location of the structural abnormality.

Coding

See the [Codes table](#) for details.

Description

Reconstructive surgery, when it meets the definition under applicable state law, is a covered benefit. It is the intent of Blue Shield of California Promise Health Plan to use definitions and make determinations consistent with the Reconstructive Surgery Act (AB 1621) which added Section 1367.63 to the California Health and Safety Code, Section 10123.88 to the Insurance Code and Section 14132.62 to the Welfare and Institutions Code.

Related Policies

- Gender Affirmation Surgery
- Panniculectomy, Abdominoplasty, and Surgical Management of Diastasis Recti
- Treatment of Varicose Veins/Venous Insufficiency

Benefit Application

Blue Shield of California Promise Health Plan is contracted with L.A. Care Health Plan for Los Angeles County and the Department of Health Care Services for San Diego County to provide Medi-Cal health benefits to its Medi-Cal recipients. In order to provide the best health care services and practices, Blue Shield of California Promise Health Plan has an extensive network of Medi-Cal primary care providers and specialists. Recognizing the rich diversity of its membership, our providers are given training and educational materials to assist in understanding the health needs of their patients as it could be affected by a member's cultural heritage.

The benefit designs associated with the Blue Shield of California Promise Medi-Cal plans are described in the Member Handbook (also called Evidence of Coverage).

Regulatory Status

State: The California Reconstructive Surgery Act (Health & Safety Code Section 1367.63 and the Insurance Code Section 10123.88) defines "reconstructive surgery" as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do **either** of the following:

- I. Create a normal appearance to the extent possible
- II. Improve function

Health Equity Statement

Blue Shield of California Promise Health Plan's mission is to transform its health care delivery system into one that is worthy of families and friends. Blue Shield of California Promise Health Plan seeks to advance health equity in support of achieving Blue Shield of California Promise Health Plan's mission.

Blue Shield of California Promise Health Plan ensures all Covered Services are available and accessible to all members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

Rationale

Blue Shield of California Promise Health Plan's intent is to use definitions and make determinations consistent with the Reconstructive Surgery Act (AB 1621) which added Section 1367.63 to the California Health and Safety Code, Section 10123.88 to the Insurance Code and Section 14132.62 to the Welfare and Institutions Code. AB 1621 (Figueroa and Leach) - Approved by the Governor September 23, 1998. Summary: Requires health insurance and health care service plan contracts to cover reconstructive surgeries. Specifically, this bill:

- Provides that health care service plans and disability insurers that cover hospital, medical or surgical benefits, including entities that provide Medi-Cal coverage, shall cover reconstructive surgeries
- Defines reconstructive surgery as surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease if the surgery will either improve function or give a patient a normal appearance

References

1. Reconstructive Surgery Act (AB 1621). 1998. Accessed on September 16, 2025 from http://www.leginfo.ca.gov/pub/97-98/bill/asm/ab_1601-1650/ab_1621_bill_19980924_chaptered.html
2. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes 10000 thru 19999. Accessed April 21, 2026, from https://mcweb.apps.prd.cammiis.medi-cal.ca.gov/assets/351D1F95-1B91-42CE-8CF4-A527B40E0120/tarandnoncd1.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO
3. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes 20000 thru 29999. Accessed April 21, 2026, from https://mcweb.apps.prd.cammiis.medi-cal.ca.gov/assets/28498959-F595-4CAE-8990-7AC8DF4583FC/tarandnoncd2.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO
4. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes 30000 thru 39999. Accessed April 21, 2026, from https://mcweb.apps.prd.cammiis.medi-cal.ca.gov/assets/D335517A-E82A-4B68-944B-4BDC24491942/tarandnoncd3.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO
5. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes 50000 thru 59999. Accessed April 21, 2026, from https://mcweb.apps.prd.cammiis.medi-cal.ca.gov/assets/A2178E0C-1094-4B94-9E27-77A8DB180824/tarandnoncd5.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO
6. Department of Healthcare Services Provider Manual Guideline. Local Educational Agency (LEA) Service: Speech Therapy. Accessed April 21, 2026, from https://mcweb.apps.prd.cammiis.medi-cal.ca.gov/assets/D12A60BC-A578-410B-ACD6-2EE8C2A93D4A/locedservspe.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO
7. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes G0000 thru G9999. Accessed April 21, 2026, from https://mcweb.apps.prd.cammiis.medi-cal.ca.gov/assets/95922E28-1647-44F7-8DCE-6F0AA1D93CFD/tarandnoncdg.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO
8. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes H0000 thru J9999. Accessed April 21, 2026, from https://mcweb.apps.prd.cammiis.medi-cal.ca.gov/assets/2C0FB6B1-AC15-4B48-A845-A2823573A3D8/tarandnoncdhj.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO
9. Department of Healthcare Services Provider Manual Guideline. TAR and Non-Standard Benefits List: Codes Q0000 thru Q9999. Accessed April 21, 2026, from https://mcweb.apps.prd.cammiis.medi-cal.ca.gov/assets/116BE94D-20C0-47AC-AE75-60FC42DB888D/tarandnoncdq.pdf?access_token=6UyVkrRfByXTZEWIh8j8QaYyIPyP5ULO

Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
 - Clinical indications for procedure/surgery
 - Documentation of any functional problems or limitations to be corrected by the procedure including the cause of the issue
 - Previous treatment(s) and response(s) (if applicable)
 - Proposed procedural treatment plan
- Office note(s) pertaining to the clinical problem and medical necessity of the procedure requested
- Quality color photographs which accurately depict the extent of the clinical problem (as applicable)

Post Service (in addition to the above, please include the following):

- Procedure/Operative report(s)

Coding

The list of codes in this Medical Policy is intended as a general reference and may not cover all codes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy.

Type	Code	Description
CPT®	11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
	11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
	11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
	11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
	11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
	11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
	11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
	15770	Graft; derma-fat-fascia
	15775	Punch graft for hair transplant; 1 to 15 punch grafts
	15776	Punch graft for hair transplant; more than 15 punch grafts
	15777	Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) (List separately in addition to code for primary procedure)
	15786	Abrasion; single lesion (e.g., keratosis, scar)
	15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
	15819	Cervicoplasty
	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
	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	

Type	Code	Description
	15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
	15876	Suction assisted lipectomy; head and neck
	15877	Suction assisted lipectomy; trunk
	15878	Suction assisted lipectomy; upper extremity
	15879	Suction assisted lipectomy; lower extremity
	17380	Electrolysis epilation, each 30 minutes
	17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
	19316	Mastopexy
	19325	Breast augmentation with implant
	19350	Nipple/areola reconstruction
	19355	Correction of inverted nipples
	19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)
	19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy
	21086	Impression and custom preparation; auricular prosthesis
	21087	Impression and custom preparation; nasal prosthesis
	21088	Impression and custom preparation; facial prosthesis
	21089	Unlisted maxillofacial prosthetic procedure
	21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
	21121	Genioplasty; sliding osteotomy, single piece
	21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., 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)
	21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
	21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)
	21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
	21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
	21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
	21209	Osteoplasty, facial bones; reduction
	21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
	21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
	21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
	21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
	21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial

Type	Code	Description
	21270	Malar augmentation, prosthetic material
	21280	Medial canthopexy (separate procedure)
	21282	Lateral canthopexy
	21299	Unlisted craniofacial and maxillofacial procedure
	21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
	21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy
	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)
	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)
	31587	Laryngoplasty, cricoid split, without graft placement
	31599	Unlisted procedure, larynx
	31750	Tracheoplasty; cervical
	55970	Intersex surgery; male to female
	55980	Intersex surgery; female to male
	56805	Clitoroplasty for intersex state
	57291	Construction of artificial vagina; without graft
	57292	Construction of artificial vagina; with graft
	57335	Vaginoplasty for intersex state
	66683	Implantation of iris prosthesis, including suture fixation and repair or removal of iris, when performed <i>(Code effective 1/1/2025)</i>
	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
HCPCS	G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)
	J0591	Injection, deoxycholic acid, 1 mg
	Q2026	Injection, Radiesse, 0.1 ml
	Q2028	Injection, sculptra, 0.5 mg

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
12/01/2025	New policy.
05/01/2026	Administrative update. State Guidelines section updated.

Effective Date	Action
06/01/2026	Administrative update. Definitions of Decision Determinations section updated.

Definitions of Decision Determinations

Healthcare Services: For the purpose of this Medical Policy, Healthcare Services means procedures, treatments, supplies, devices, and equipment.

Medically Necessary or Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

Criteria Determining Experimental/Investigational Status

Below is an excerpt of the language taken from California Children's Services Numbered Letter 05-1020.*

*Department of Healthcare Services Numbered Letter 05-1020. Accessed April 21, 2026, from <https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-05-1020-Experimental-and-Investigational-Services.pdf>

Policy

- A. The California Children's Services (CCS) Program and the Genetically Handicapped Persons Program (GHPP) will not provide coverage for experimental services unless specifically authorized by law.
- B. The CCS Program and GHPP may provide coverage for an investigational service if:
 1. It is approved by the FDA under any Investigational New Drug (IND) Application; or
 2. It is authorized for use under the State of California's Right to Try Act; and
 3. Its use is consistent with its FDA-approved IND Application or the State of California's Right to Try Act;
- C. Additional criteria that will be considered in the adjudication process include:
 1. Conventional therapy will not adequately treat the intended patient's condition;
 2. Conventional therapy will not prevent progressive disability or premature death;
 3. The provider of the proposed service has a record of safety and success with it or equivalent to that of other providers of the investigational services;
 4. Other criteria (e.g., cost and availability) may be considered in the adjudication of a given request in cases in which more than one investigational service is available;
 5. There is reasonable expectation that the investigational service will significantly prolong the patient's life or will maintain or restore a range of physical and social function suited to activities of daily living; and
 6. The service is not being performed as part of a research study protocol. For a beneficiary with cancer who participates in a clinical trial for cancer, California Health and Safety Code (HSC) § 1370.6 requires that all routine patient care costs related to the clinical trial be covered if the beneficiary's CCS-paneled treating physician recommends participation

in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the enrollee. The coverage does not include investigational services that have not been approved by the FDA and that are associated with the clinical trial.

Feedback

Blue Shield of California Promise Health Plan is interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration. Our medical policies are available to view or download at www.blueshieldca.com/en/bsp/providers.

For medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Questions regarding the applicability of this policy should be directed to the Blue Shield of California Promise Health Plan Prior Authorization Department at (800) 468-9935, or the Complex Case Management Department at (855) 699-5557 (TTY 711) for San Diego County and (800) 605-2556 (TTY 711) for Los Angeles County or visit the provider portal at www.blueshieldca.com/en/bsp/providers.

Disclaimer: Blue Shield of California Promise Health Plan may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as member health services contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member health services contracts may differ in their benefits. Blue Shield of California Promise Health Plan reserves the right to review and update policies as appropriate.

Appendix A

State Guidelines/Policy Statement (No changes)	
BEFORE	AFTER
<p>Reconstructive Services PHP_7.08</p> <p>State Guidelines: Applicable Medi-Cal guidelines as of the publication of this policy (this guideline supersedes the criteria in the Policy Statement section below):</p> <p>I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline:</p> <ul style="list-style-type: none"> • N/A <p>II. Department of Health Care Services (DHCS) Provider Manual Guideline:</p> <ul style="list-style-type: none"> • TAR and Non-Standard Benefits List: Codes 10000 thru 19999 (tar and non cd1) • TAR and Non-Standard Benefits List: Codes 20000 thru 29999 (tar and non cd2) • TAR and Non-Standard Benefits List: Codes 30000 thru 39999 (tar and non cd3) • TAR and Non-Standard Benefits List: Codes 50000 thru 59999 (tar and non cd5) • Local Educational Agency (LEA) Service: Speech Therapy (loc ed serv spe) • TAR and Non-Standard Benefits List: Codes G0000 thru G9999 (tar and non cdg) • TAR and Non-Standard Benefits List: Codes H0000 thru J9999 (tar and non cdhj) • TAR and Non-Standard Benefits List: Codes Q0000 thru Q9999 (tar and non cdq) <p>The codes listed on the policy are included in the above Provider Manuals; however, there are no specific clinical guidelines.</p>	<p>Reconstructive Services PHP_7.08</p> <p>State Guidelines: Applicable Medi-Cal guidelines as of the publication of this policy (this guideline supersedes the criteria in the Policy Statement section below):</p> <p>I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline:</p> <ul style="list-style-type: none"> • N/A <p>II. Department of Health Care Services (DHCS) Provider Manual Guideline:</p> <ul style="list-style-type: none"> • TAR and Non-Standard Benefits List: Codes 10000 thru 19999 (tar and non cd1) • TAR and Non-Standard Benefits List: Codes 20000 thru 29999 (tar and non cd2) • TAR and Non-Standard Benefits List: Codes 30000 thru 39999 (tar and non cd3) • TAR and Non-Standard Benefits List: Codes 50000 thru 59999 (tar and non cd5) • Local Educational Agency (LEA) Service: Speech Therapy (loc ed serv spe) • TAR and Non-Standard Benefits List: Codes G0000 thru G9999 (tar and non cdg) • TAR and Non-Standard Benefits List: Codes H0000 thru J9999 (tar and non cdhj) • TAR and Non-Standard Benefits List: Codes Q0000 thru Q9999 (tar and non cdq) <p>The codes listed on the policy are included in the above Provider Manuals; however, there are no specific clinical guidelines.</p>

State Guidelines/Policy Statement (No changes)	
BEFORE	AFTER
<p>III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline:</p> <ul style="list-style-type: none"> • N/A <p>Policy Statement: Any criteria that are not specifically addressed in the above Provider Manuals, please refer to the criteria below.</p> <p>I. In interpreting whether a proposed procedure meets the definition of reconstructive surgery, as defined by law, the procedure may be denied as not medically necessary under any of the following conditions:</p> <ul style="list-style-type: none"> A. The procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by providers specializing in reconstructive surgery B. The treating surgeon cannot or will not provide sufficient documentation, including (when appropriate) medical quality color photographs, which accurately depicts the extent of the clinical problem (see <u>Policy Guidelines</u> and <u>Documentation for Clinical Review</u> sections) C. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes D. The procedure is for <u>cosmetic</u> purposes only <p>II. The use of silicone type injectables (e.g., Sculptra) to treat HIV-related lipoatrophy when it is likely that the injection(s) will result in more than minimal improvement in appearance may be considered medically necessary.</p>	<p>III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline:</p> <ul style="list-style-type: none"> • N/A <p>Policy Statement: Any criteria that are not specifically addressed in the above Provider Manuals, please refer to the criteria below.</p> <p>I. In interpreting whether a proposed procedure meets the definition of reconstructive surgery, as defined by law, the procedure may be denied as not medically necessary under any of the following conditions:</p> <ul style="list-style-type: none"> A. The procedure is likely to result in only minimal improvement in appearance, in accordance with the standard of care as practiced by providers specializing in reconstructive surgery B. The treating surgeon cannot or will not provide sufficient documentation, including (when appropriate) medical quality color photographs, which accurately depicts the extent of the clinical problem (see <u>Policy Guidelines</u> and <u>Documentation for Clinical Review</u> sections) C. There is an alternative approved medical or surgical intervention with equal or superior clinical outcomes D. The procedure is for <u>cosmetic</u> purposes only <p>II. The use of silicone type injectables (e.g., Sculptra) to treat HIV-related lipoatrophy when it is likely that the injection(s) will result in more than minimal improvement in appearance may be considered medically necessary.</p>