REIMBURSEMENT POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Cosmetic and Reconstructive Services-GA MCD-PY-1674	11/01/2025
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Cosmetic and Reconstructive Services

B. Background
Cosmetic treatments are services that are performed solely to alter a patient's appearance and are typically not covered by health insurance plans. There are certain procedures, however, that may be considered either cosmetic or reconstructive. A reconstructive service is differentiated from a cosmetic treatment by the patient's condition and the purpose and intent of the procedure.

C. Definitions
- **Cosmetic Procedure** – Is performed for aesthetic purposes and is not medically necessary.
- **Reconstructive Procedures** – Is both medically necessary and primarily to restore or improve function or to correct deformity resulting from congenital or developmental anomaly, disease, trauma, or previous therapeutic or surgical process.

D. Policy
I. Cosmetic procedures are **NOT** medically necessary and are **NOT** reimbursable.

II. Reconstructive procedures are reimbursable when medical necessity is met. The following services outline general requirements for reimbursement. CareSource may request additional documentation.
A. Chemical Peels
Chemical peels are considered cosmetic procedures and are **NOT** reimbursable.
B. Vascular Lesions
1. Treatment is reimbursable when documentation shows significant functional impairment, such as bleeding or lesion interfering with vision, and the procedure is reasonably expected to improve the functional impairment.
2. Treatment is performed to correct a significant variation from normal human anatomy due to a congenital defect.
C. Dermabrasion
1. Treatment for actinic keratoses, pre-malignant skin lesions, and localized non-melanoma malignant skin lesions is reimbursable.
2. Treatment is considered **NOT** reimbursable when there is no significant functional impairment and is intended to change a physical appearance within normal human anatomic variation, such as acne scars and uneven pigmentation.
D. Hair Procedures
1. Permanent hair removal is reimbursable when performed for
a. pilonidal cyst
b. pilonidal sinus
c. pilar cyst
d. trichodermal cyst

e. follicular disorder
2. All other hair removal and hair transplantation are considered a cosmetic procedure and are **NOT** reimbursable.

E. Laser and Surgical Treatment of Rosacea and Telangiectasia
1. Treatment for rosacea is reimbursable when:
   a. Rosacea is severe.
   b. Refractory to standard medical therapy.
   c. Preoperative photos document clinical skin changes requiring treatment.
2. Telangiectasia must not be isolated, including spider veins, and cause significant functional impairment to be reimbursable.
3. All other indications for laser skin resurfacing, such as acne scars and facial wrinkles, are considered **NOT** reimbursable and are cosmetic.

F. Tattoos
1. Skin tattooing is reimbursable when performed as part of a medically necessary therapeutic treatment, such as radiation therapy.
2. Skin tattooing is reimbursable when performed as part of a covered breast reconstruction.
3. Tattoo removal or excision is **NOT** reimbursable and is considered cosmetic.

E. Conditions of Coverage

Reimbursement policies are designed to assist providers when submitting claims to CareSource and are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify a member's eligibility.

Reimbursement is dependent upon, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

Providers must follow proper billing, industry standards, and state compliant codes on all claim submissions. The use of modifiers must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, CareSource policies apply to both participating and nonparticipating providers and facilities.

F. Related Policies/Rules

N/A

G. Review/Revision History

	DATE	ACTION
Date Issued	07/30/2025	Approved at Committee.
Date Revised		
Date Effective	11/01/2025	

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.

Date Archived		

H. References

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