Medical Policy & Procedure

Policy Name:	Medical Policy: Cosmetic, Post Accidental/ Surgical Trauma, and Reconstructive Surgery	Policy #:	MP-192

Policy Information

Owner Department:	Medical UM & Systems Department
Owner:	Assigned Medical Director
Electronic Signature/Date:	Krystal Revai (01/15/2024), Lori Slaughter (01/11/2024)

If there is a discrepancy between a medical policy and a patient's policy or plan document/summary plan description, the policy or plan document/summary plan descriptions provisions and limitations will govern the determination of benefits.

Purpose of the Policy

To make utilization decisions, Health Alliance uses written criteria based on sound clinical evidence for appropriately applying the criteria.

Statement of the Policy

To apply objective and evidence-based criteria when determining the medical appropriateness of health care services.

Health Alliance does not cover cosmetic surgery that is not medically necessary. Coverage is generally provided when the surgery is needed to improve the functioning of a body part or is otherwise medically necessary.

Cosmetic procedures based on psychiatric, psychosocial or emotional issues are excluded from coverage.

Applies To

- Preauthorization is required for all contracted providers.
- Self-Funded Plans: Refer to the Preauthorization Section of the Group's Plan Document.
- Medicare Advantage: Refer to the Coverage Issues and Carrier Manual.

Interpretations

1. The following are considered medically necessary reconstructive procedures when specific Medical Policy (MP) or criteria below are met:

1.1 Abdominoplasty/Panniculectomy (MP-141)
1.2 Blepharoplasty and Eyelid/Brow Ptosis Repair (MP-14)
1.3 Breast Reconstruction, Revision of Reconstruction, and Implant Removal and Replacement (MP-20)
1.4 Gynecomastia (MP-39)
1.5 Skin and Soft Tissue Lesions - Removal in a Facility (MP-47)
1.6 Laser Treatment of Port-Wine Stains - Hemangiomas (MP-144)
1.7 Reduction Mammoplasty, Female (MP-159)
1.8 Skin Substitutes and Application Criteria (MP-172)
1.9 Uvulopalatopharyngoplasty (UPPP) (MP-81)
1.10 Rhinoplasty (MP-219)

1.11 Laser Treatment of Psoriasis and Other Dermatology Conditions (MP-140)
1.12 Dental Services (MP-171)
1.13 Endovenous Laser & Radiofrequency Therapy for Varicose Veins (MP-202)
1.14 Collagen implants for urinary incontinence (See Urinary Dysfunction Treatments (MP-294)
1.15 Bulking agents for vocal cord paralysis/insufficiency: Cover Radiesse, CYmetra, Restyland, or autologous fat injection (Ref. #5)
1.16 Intralesional injection of steroid for the treatment of inflammatory nodulo-cystic acne only
1.17 Intralesional injection of steroid for treatment of keloids and hypertrophic scars which are painful or cause functional impairment (Ref. #4)
1.18 Intralesional injection of steroid for treatment of alopecia areata
1.19 Masculinization/feminization surgical procedures. Please see Gender Affirmation Surgery Medical Policy – MP-305. These procedures are considered cosmetic and not covered unless mandated by the state for members with gender dysphoria.
1.20 Nuss Procedure for Pectus Excavatum, See Pectus Excavatum: Surgical Correction (MP-304)
1.21 Advanced Nodular Rhinophyma: Health Alliance covers surgical excision with/without skin grafting or shaving for the treatment of advanced nodular rhinophyma (CPT 30120) when:
  1.21.1 There is need for repeated cautery of bleeding telangiectasias or frequent courses of antibiotics for pustular eruptions, OR
  1.21.2 There is chart documentation of a chronic functional impairment (e.g., chronic nasal airway obstruction), AND
  1.21.3 Frontal, lateral, and work's eye photographs clear document advanced nodular rhinophyma.
1.22 Testicular (CPT 54660) and Penile (CPT 54400, 54401, or 54405) prostheses are covered for replacement of congenitally absent testes, or testes lost due to disease, injury, or surgery and for gender affirmation surgery when medically necessary, except for Self-Funded Plans when excluded.
1.23 Facial Lipodystrophy Syndrome diagnosed to be caused by antiretroviral therapy in HIV-infected persons, is covered for treatment with the Injectable fillers approved by the Food and Drug Administration (FDA), Radiesse® HCPCS Q2026 or Sculptra® HCPCS Q2028. Coverage requires submission of high-quality facial photographs, clinical records, and appropriate laboratory findings by a physician who regularly cares for affected members and performs the injections. Requires use of CPT filler injection codes 11950-11954 and the product Q code. (Ref. #6). See Medicare Advantage coverage under Criteria 4.1 below.

2. Cosmetic surgery following accidental trauma or severe disfigurement due to cancer surgery is covered on a case-by-case basis when:

2.1 The specific conditions addressed by InterQual or other Health Alliance Medical Policies in Section 1 above do not apply; and
2.2 It is needed to improve the functioning of a body part; and
2.3 The disfigurement is severe and can be expected to show significant improvement in appearance with surgery; and
2.4 The Primary Care Physician (PCP) and/or attending physician offers input as to appropriateness, expected results, and timing after the traumatic injury.

3. Cosmetic procedures (Services that are provided primarily to alter and/or enhance appearance in the absence of documented impairment of physical function) are considered not medically necessary and include, but are not limited to:

3.1 The above procedures in Section 1 when medical necessity criteria are not met,
3.2 Excision of excessive skin, including wrinkles and/or skin subcutaneous soft tissue in all body areas (CPT 15819, 15824-15829[rhytidectomy – "face lift"] 15832-15839),
3.3 Tattooing (CPT 11920-11922), except for Nipple/Areolar Tattooing, see Breast Reconstruction, Revision of Reconstruction, and Implant Removal and Replacement Medical Policy, and Tattoo removal (salabrasion) (CPT 15783),

3.4 Fat grafts (CPT 15771-15774) (exception: autologous fat transplants post-mastectomy only), see Breast Reconstruction, Revision of Reconstruction, and Implant Removal and Replacement Medical Policy
3.5 Laser or electrolysis hair removal (CPT 17380), except for limited affirmation genital surgeries, See Gender Affirmation Surgery Medical Policy,
3.6 Liposuction/Lipectomy—suction-assisted fat removal (CPT 15876, 15878-15879), except for some breast contouring and abdominal wall procedures, See Breast Reconstruction, Revision of Reconstruction, and Implant Removal and Replacement and Abdominoplasty/Panniculectomy Medical Policies
3.7 Telangiectasis removal (spider angiomata/veins) (CPT 36468),
3.8 Labioplasty/Clitoroplasty (CPT 56805)/Vaginoplasty/vagina rejuvenation procedures (CPT 57292, 57295, 57296),
3.9 Dermal filler injections, e.g., calcium hydroxylapatite, polylactic acid (CPT injection codes 11950-11954), other than covered above in Criteria 1.14 and 1.15,
3.10 Facial implants (e.g., genioplasty (CPT 22120-21123), mentoplasty (CPT 21125-21127), malar (CPT 21270)) to improve appearance, forehead reduction (CPT 21137-21139) [See Gender Affirmation Surgery policy for possible mandate exceptions]
3.11 Correction of "Prominent" ears (CPT 69300)
3.12 Acne phototherapy
3.13 Aesthetic operations on umbilicus (CPT 49250)
3.14 Buttock lift or augmentation
3.15 Piercing of ear (CPT 69090) and ear gauge procedure (also known as spacers, tunnels, cogs, caps or plugs) are a form of body jewelry that slowly expands the earlobe/body part over time) or closure or repair of stretched pierced earring hole (CPT 69300) and repair of any other body part damaged due to piercing or gauge procedures
3.16 Collagen implant, CPT injection codes: 11950-11954, except for urinary incontinence treatment, Criteria 1.14 above.
3.17 Correction of diastasis recti abdominis (see Abdominoplasty/Panniculectomy policy)
3.18 Correction of inverted nipple (CPT 19355)
3.19 Laser treatment for Acne Vulgaris
3.20 Laser treatment for Rosacea
3.21 Photodynamic therapy with 5-Amniolevolinic Acid (J7308) for recalcitrant Familial Benign Pemphigus (Hailey-Hailey Disease)
3.22 Laser treatment of post-inflammatory hypopigmentation from psoriasis, or for Vitiligo and other skin pigmentation changes such as dyschromia (CPT 96920-96922)
3.23 Removal of supernumerary nipples (polymastia)
3.24 Hair Transplants (CPT 15775-15776)
3.25 Acne Cryotherapy (CO_2 slush, liquid N_2) [CPT 17340]
3.26 Dermabrasion (total face for acne scarring, fine wrinkling, rhytids, general keratosis; segmental, face or regional, other than face) (CPT 15780-15782)
3.27 Chemical peels (CPT 15788-15789, facial; 15792-15793, non-facial) are considered cosmetic, except for members with wide-spread actinic keratosis who have failed to adequately respond to topical imiquimod or 5-FU, or to cryosurgery. Also see Skin and Soft Tissue Lesions - Removal in a Facility, MP-47.
3.28 Insertion of Tissue Expanders not breast related, including subsequent expansion (CPT 11960)

See also Medical Policy – Complications Arising From Non-Covered Services

4. Medicare Advantage Criteria Details:

4.1 Facial Lipodystrophy Syndrome: National Coverage Analysis (NCA) Decision Memo: Dermal Injections for the treatment of Facial Lipodystrophy Syndrome (FLS). CAG-00412N Decision Summary: Dermal injections for facial lipodystrophy syndrome (FLS) are only reasonable and necessary

using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in HIV infected beneficiaries when Facial LDS caused by antiretroviral HIV treatment is a significant contributor to their depression. All other indications are non-covered. NCD - Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (250.5) (cms.gov)

- NCA - Dermal injections for the treatment of facial lipodystrophy syndrome (FLS) (CAG-00412N) (cms.gov)
- Article - Billing and Coding: Cosmetic and Reconstructive Surgery (A58774) (cms.gov)

4.2 All Other Cosmetic Procedures: *See Medicare Policy - Medicare Benefit Policy Manual – Chapter 16 100-02, Section 120: Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.*

Codes

*Codes listed are for informational purposes only and do not necessarily indicate prior authorization is or is not required or coverage is guaranteed.

Providers are required to indicate the diagnosis and procedure codes when requesting review of coverage.

References

1. Cosmetic Surgery, Aetna Clinical Policy Bulletin Number: 0031. 3/06/09.
2. Wikipedia, The Free Encyclopedia. The Wikipedia Foundation. January 18, 2010.
3. Cosmetic and Reconstructive Surgery, Regence Medical Policy. January 1, 2010.
4. Goldstein AO, Hong AM. Keloids and hypertrophic scars. In; UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Accessed September 20, 2021.)
5. Miaskiewicz B, et al. Comparison of 24-month voice outcomes after injection laryngoplasty with calcium hydroxylapatite or hyaluronic acid in patients with unilateral vocal fold paralysis. *Am J Otolaryngol.* 2022 Jan-Feb; 43(1):103207.
6. Kim J, Song SY, et al. Treatment of Human Immunodeficiency Virus-Associated Facial Lipoatrophy with Hyaluronic Acid Filler Mixed with Micronized Cross-Linked Acellular Dermal Matrix. *J Korean Med Sci.* 2022 Feb 7; 37(5):e37.

History

Created Date:	03/10/10 – MDC		
Effective Date:	03/10/10		
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Revision Date:	03/10/10 – MDC	03/14/12 – MDC	05/22/13 – MDC
	01/09/14 – MDC-Revised to add statement that Criteria 1.1 do not apply to the specific conditions addressed by InterQual or other Health Alliance Medical Policies.		
	04/14/14	02/24/15	
	02/09/16 – MDC Revision-Added definition of cosmetic procedure and included non-coverage of prominent ears as cosmetic.		
	03/08/17	03/14/18	

	09/17/19 – MDC-Annual review, no changes.		
	08/26/20 – MDC-Annual review, added reference to Breast Reconstruction policy in 2.4, added 2.25 for Acne Cryotherapy.		
	10/19/21 – MDC-Annual review, updated policy layout.		
	12/20/22 – MDC-Annual review, procedures (Nuss, dermabrasion, chemical peels, piercing/gauging, etc) and codes added, addition of reviewing Gender Affirmation Surgery policy for mandated coverage.		
	11/21/23 – MDC-Annual review, addition of language for covered/non-covered services and CPT codes, things discussed at previous meetings embedded - dermal fillers for HIV lipodystrophy, treatment for rhinophyma.		