**MEDICAL COVERAGE POLICY**

**SERVICE: Cosmetic Procedures and Treatment**

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| **Policy Number:** | **263** |
| **Effective Date:** | **07/01/2020** |
| **Last Review:** | **05/28/2020** |
| **Next Review Date:** | **05/28/2021** |

**Important note:**
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

**SERVICE:** Cosmetic Procedures and Treatment

**PRIOR AUTHORIZATION:** May be required.

**POLICY:** SWHP/FC plans exclude coverage of cosmetic surgery that is not medically necessary, but may provide coverage when the surgery is needed to improve the functioning of a body part, or is otherwise medically necessary, even if the surgery also improves or changes the appearance of a portion of the body. Additionally, many SWHP/FC plans specify that certain procedures are not considered to be cosmetic surgery (e.g., surgery to correct the result of injury, post-mastectomy breast reconstruction, surgery needed to treat certain congenital defects such as cleft lip or cleft palate). Please check benefit plan descriptions for details.

**For Medicare plans**, please confirm coverage as outlined in Novitas-Solutions LCDs

**For Medicaid plans**, please confirm coverage as outlined in the Texas Medicaid TMPPM.

This policy **supplements** plan coverage language by listing some procedures that are always considered cosmetic, and those that may be medically necessary despite cosmetic aspects. Please note that, while this policy addresses many common procedures, it does not address **ALL** procedures that might be considered to be cosmetic and thus excluded from coverage. SWHP/FC reserve the right to deny coverage for other procedures that are cosmetic and not medically necessary.

The following procedures are primarily for altering and/or enhancing appearance in the absence of documented impairment of physical function, and thus **are considered cosmetic**:

- Aesthetic alteration of the female genitalia (e.g., hymenoplasty, inverted V hoodoplasty, labiaplasty, and mons pubis-pexy)
- Aesthetic operations on umbilicus
- Breast augmentation (breast implants and pectoral implants) unless required under Women's Health and Cancer Rights Act (WHCRA)
- Breast lift (mastopexy)
- Buttock lift or augmentation

- Cheek implant (malar implant/augmentation)
- Chin implant (genioplasty, mentoplasty)
- Correction of diastasis recti abdominis
- Correction of inverted nipple, unless related to cancer surgery.
- Ear or body piercing
- Electrolysis or laser hair removal
- Excision of excessive skin of thigh (thigh lift, thighplasty), leg, hip, buttock, arm (arm lift, brachioplasty), forearm or hand, submental fat pad, or other areas
- Intense pulsed light laser for facial redness
- Lacrimal gland resuspension for lacrimal gland prolapse
- Mesotherapy (injection of various substances into the tissue beneath the skin to sculpt body contours by lysing subcutaneous fat)
- Neck Tucks
- Removal of frown lines
- Removal of spider angiomata
- Removal of supernumerary nipples (polymastia)
- Salabrasion
- Selective neurectomy of the gastrocnemius muscle for correction of calf hypertrophy
- Surgery for body dysmorphic disorder
- Surgery to correct moon face
- Surgery to correct tuberous breast deformity
- Surgical depigmentation (e.g., laser treatment) of nevus of Ito or Ota
- Tattoo removal
- Treatment with small gel-particle hyaluronic acid (e.g., Restylane) and large gel-particle hyaluronic acid (e.g., Perlane) to improve the skin's contour and/or reduce depressions due to acne, injury, scars, or wrinkles
- Vaginal rejuvenation procedures (clitoral reduction, designer vaginoplasty, hymenoplasty, re-virgination, G-spot amplification, pubic liposuction or lift, reduction of labia minora, labia majora surgery/reshaping, thermal therapy (e.g., radiofrequency (ThermiVa and Viveve procedures) and laser) and vaginal tightening, not an all-inclusive list)

The following procedures **may be considered medically necessary when criteria are met.** The requesting physicians may be required to submit documentation, including photographs, letters documenting medical necessity, chart records, etc.:

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| Abdominoplasty: may be considered medically necessary when surgery is performed to alleviate such complicating factors as inability to walk normally, chronic pain, ulceration created by the abdominal skin fold, or intertrigal dermatitis. | IQ, Pol 083/ L35090 | 15847 |

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| Blepharoplasty: may be considered medically necessary when criteria are met. | IQ/ L35004 | 15820, 15821, 15822, 15823 |
| Breast reduction: may be considered medically necessary when criteria are met. | Pol 209/ L35090 | 19318 |
| Chemical peels (chemical exfoliation): may be considered medically necessary when:<br>✓ The member has actinic keratoses OR other pre-malignant skin lesions, AND<br>✓ The member has 15 or more lesions, AND<br>✓ The member has tried treatment with topical 5-FU or imiquimod OR it is contraindicated | Listed Criteria | 15788, 15789 |
| Dermabrasion: may be considered medically necessary when correcting defects resulting from traumatic injury, surgery or disease or for the treatment of rhinophyma, OR:<br>✓ The member has superficial basal cell carcinomas OR pre-cancerous actinic keratoses, AND<br>✓ Conventional methods of removal such as cryotherapy, curettage, and excision, are impractical due to the number and distribution of the lesions, OR<br>✓ The member has failed a trial of 5-fluorouracil (5-FU) (Efudex) or imiquimod (Aldara) OR it is contraindicated | Listed Criteria/ L35090 | 15780, 15781, 15782, 15783, 15786 |
| Dermal and subcutaneous injections of filling material may be medically necessary as part of breast reconstruction following breast cancer surgery.<br>Dermal injections may be considered medically necessary for members with HIV having facial lipodystrophy syndrome due to antiretroviral therapy, AND the fillers being used are FDA approved (e.g., poly-L-lactic acid dermal injection (Sculptra) or calcium hydroxylapatite dermal injection (Radiesse)) | Listed Criteria | 11950, 11951, 11952, 11954, G0429 |
| Hair removal may be considered medically necessary for one of the following:<br>✓ Recurrent infected cyst<br>✓ Hair follicle infections<br>✓ After surgical treatment of pilonidal sinus disease | Listed Criteria | 17380 |
| Keloids: Repair of keloids may be considered medically necessary if they cause pain or a functional limitation. | Listed Criteria | |
| Lipomas: Excision may be considered medically necessary if lipomas are tender and inhibit the member's ability to perform daily activities due to the lipomas' location on body parts that are subject to regular touch or pressure. All under indications for lipectomy are considered cosmetic and thus not a covered benefit. | Listed Criteria | 15876, 15877, 15878, 15879 |
| Otoplasty: may be considered medically necessary when being performed to improve hearing by directing sound in the ear canal due to ears being absent or deformed from trauma, surgery, disease, or congenital defect. | Listed Criteria | 69300 |

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| Otoplasty to correct large or protruding ears (bat ears) is considered cosmetic when the surgery will not improve hearing. | | |
| Panniculectomy: may be considered medically necessary when criteria are met. | IQ, Pol 083/ L35090 | 15830 |
| Pulsed-dye laser treatment and excision of port wine stains and other hemangiomas. See Medical Policy 099 – Laser Treatment of Skin Lesions | 099/ L34938 | 17106, 17107, 17108 |
| Rhytidectomy: may be considered medically necessary when there is functional impairment that cannot be corrected without surgery. | Listed Criteria | 15824, 15825, 15826, 15828, 15829 |
| Scar revision: Repair of scars that result from surgery may be considered medically necessary if they cause symptoms or functional impairment. | Listed Criteria | 15786 |
| Tattoo: may be considered medically necessary in conjunction with reconstructive breast surgery post-mastectomy, and for marking for radiation therapy. | Listed Criteria | 11920, 11921, 11922 |
| True incisional or ventral hernia repair (not diastasis recti) | Necessary | |
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**For Medicare plans**, please confirm coverage as outlined in Novitas-Solutions LCDs

## CODES:

***Important note:***

*CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.*

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| CPT Codes: | |
| CPT Not Covered: | |
| ICD10 codes: | |
| ICD10 Not covered: | |

**CMS:** LCD L35090 and associated LCA A56587 contain information regarding Medicare coverage of potentially cosmetic procedures.

## POLICY HISTORY:

| Status | Date | Action |
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| New | 04/22/2020 | New policy |

## REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. SWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.