MEDICAL COVERAGE POLICY

SERVICE:	**Cosmetic Procedures and Treatment**
Policy Number:	**263**
Effective Date:	**07/01/2024**
Last Review:	**05/13/2024**
Next Review:	**05/13/2025**

Important note: *Unless otherwise indicated, medical policies will apply to all lines of business. Medical necessity as defined by this policy does not ensure the benefit is covered. This medical policy does not replace existing federal or state rules and regulations for the applicable service or supply. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan documents. See the member plan specific benefit plan document for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. In the event of a discrepancy, the plan document always supersedes the information in this policy.*

SERVICE: Cosmetic Procedures and Treatment

PRIOR AUTHORIZATION: May be required.

POLICY:

BSWHP 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 BSWHP 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.

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. BSWHP reserves the right to deny coverage for other procedures that are cosmetic and not medically necessary.

Note: Unless otherwise indicated (see below), this policy will apply to all lines of business.

For Medicare plans, please refer to appropriate Medicare NCD (National Coverage Determination) or LCD (Local Coverage Determination). Medicare NCD or LCD specific InterQual criteria may be used when available. If there are no applicable NCD or LCD criteria, use the criteria set forth below.

L35004 Blepharoplasty, Blepharoptosis Repair and Surgical Procedures of the Brow
L35090 Cosmetic and Reconstructive Surgery
A56587 Billing and Coding: Cosmetic and Reconstructive Surgery
L34938 Removal of Benign Skin Lesions

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid Provider Procedures Manual | TMHP (TMPPM). If there are no applicable criteria to guide medical necessity decision making in the TMPPM, use the criteria set forth below.

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.):

Procedure	Criteria / Reference	Code(s)
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 intertriginous dermatitis.	InterQual Med Policy 083 L35090	15847
Blepharoplasty - May be considered medically necessary when criteria are met.	InterQual L35004	15820 15821 15822 15823
Breast reduction - May be considered medically necessary when criteria are met.	Med Policy 209 L35090	19318
Chemical peels (chemical exfoliation) - May be considered medically necessary when: • The member has actinic keratoses OR other pre-malignant skin lesions, AND • The member has 15 or more lesions, AND • The member has tried treatment with topical 5-fluorouracil (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: • The member has superficial basal cell carcinomas OR pre-cancerous actinic keratoses, AND • Conventional methods of removal such as cryotherapy, curettage, and excision, are impractical due to the number and distribution of the lesions, AND • 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. **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: • Recurrent infected cyst • Hair follicle infections • 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.	Med Policy 099	

Lipomas - Excision may be considered medically necessary if lipomas are tender and inhibit the member's ability to perform daily activities due to the lipoma's location on body parts that are subject to regular touch or pressure. All other 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. Otoplasty to correct large or protruding ears (bat ears) is considered cosmetic when the surgery will not improve hearing.	Listed Criteria	69300
Panniculectomy - May be considered medically necessary when criteria are met. **Panniculectomy is NOT covered** when performed as an adjunct to other medically necessary procedures (e.g., hysterectomy, ventral/incisional hernia repair) unless the criteria for panniculectomy are independently met.	InterQual L35090	15830
Laser Treatment - May be considered medically necessary when criteria are met.	Med Policy 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
Skin tag removal - may be considered medically necessary for recurrent bleeding.	Listed Criteria	11200 11201
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)	Medically Necessary	

BACKGROUND / DEFINITIONS:

Abdominoplasty - A surgical procedure which includes the excision of skin and subcutaneous fat in the abdomen, and a range of secondary nonfunctional procedures (e.g., transposition of the umbilicus, repair of lax abdominal muscles and suction assisted liposuction). The procedure is also referred to as a “tummy tuck” because it produces a flatter, firmer, tighter stomach and thin waist and provides an overall improvement in the person’s shape and figure. Panniculectomy and abdominoplasty are often performed together to achieve the best cosmetic result, but abdominoplasty is an add-on procedure

that is not covered.

Intertrigo - An inflammation of the body folds, most often due to chafing together of warm, moist skin, and usually located in the inner thighs, armpits, and underside of the breasts or belly. Most common in those who are overweight or diabetic, intertrigo is red and raw looking, and may itch, ooze or be sore; infection with bacteria or yeast may develop in the broken skin.

Lipectomy - A surgical technique that is used to cut and remove unwanted fat deposits from specific areas of the body. It is not a substitute for weight reduction but is a method of removing localized fat that does not respond to dieting and exercise. A lipectomy may be done for cosmetic reasons or to treat functional impairment.

Panniculectomy - Surgical excision of redundant (excess) hanging abdominal skin and fat (panniculus, pannus, apron), not including muscle plication or neoumbilicoplasty as in an abdominoplasty. The most common indication is the patient who develops redundant tissue following significant weight loss. There is a risk of complications when this tissue reaches a certain size—such as intertriginous dermatitis, cellulitis, skin ulceration, impaired mobility and interference with ADLs.

According to the American Society of Plastic Surgeons (ASPS), the severity of abdominal deformities is graded as follows:

- Grade 1: Panniculus covers hairline and mons pubis but not the genitals
- Grade 2: Panniculus covers genitals and upper thigh crease
- Grade 3: Panniculus covers upper thigh
- Grade 4: Panniculus covers mid-thigh
- Grade 5: Panniculus reaches the knees and below

Panniculitis - Intertriginous rashes, ulcerations, and/or infections that develop in the abdominopelvic fold.

Physical Functional Impairment - A condition in which the normal or proper action of a body part is damaged and affects the ability to participate in activities of daily living. Physical functional impairments include, but are not limited to, problems with ambulation, communication, respiration, swallowing, vision, or skin integrity. A physical functional impairment may impact an individual's emotional well-being or mental health, but such impact is not considered in determining whether or not a physical functional impairment exists.

CODES:

Important note: *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.*

CPT Codes	See table above

CPT Not Covered	See table above
ICD10 codes	See table above
ICD10 Not covered	See table above

POLICY HISTORY:

Status	Date	Action
New	04/22/2020	New policy
Reviewed	05/27/2021	No changes
Reviewed	05/26/2022	No changes
Reviewed	07/27/2023	Clarified and updated information
Reviewed	05/13/2024	Formatting changes, added hyperlinks to CMS and TMPPM resources, beginning and ending note sections updated to align with CMS requirements and business entity changes. Added "BACKGROUND / DEFINITIONS" section. Added language and references for Panniculectomy from retired Medical Policy 083 – Panniculectomy.

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. BSWHP 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 BSWHP 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.

1. American Society of Plastic Surgeons Recommended Insurance Coverage Criteria for Third Party Payers-Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients
2. Ramirez OM. Abdominoplasty and abdominal wall rehabilitation: A comprehensive approach. Plast Reconstr Surg. 2000;105(1):425-435.
3. Elbaz JS, Flageul G, Olivier-Masveyraud F. 'Classical' abdominoplasty. Ann Chir Plast Esthet. 1999;44(4):443461.
4. Vastine VL, Morgan RF, Williams GS, et al. Wound complications of abdominoplasty in obese patients. Ann Plast Surg. 1999;42(1):34-39.
5. Cardenas-Camarena L, Gonzalez LE. Large-volume liposuction and extensive abdominoplasty: A feasible alternative for improving body shape. Plast Reconstr Surg. 1998;102(5):1698-1707.Aly AS, Cram AE, Chao M, et al. Belt lipectomy for circumferential truncal excess: The University of Iowa experience. Plast Reconstr Surg. 2003;111(1):398-413.
6. Golladay ES. Abdominal hernias. eMedicine General Surgery Topic 2703. Omaha, NE: eMedicine.com; updated July 9, 2002. Available at: http://www.emedicine.com/med/topic2703.htm Accessed April 22, 2004.
7. State of Minnesota, Health Technology Advisory Committee. Tumescent liposuction. Technology Assessment. St. Paul, MN: HTAC; 2002.
8. Cooter R, Robinson D, Babidge W, et al. Systematic review of ultrasound-assisted lipoplasty: Update and reappraisal. ASERNIP-S Report No. 17. North Adelaide, SA: Royal Australasian College of Surgeons, Australian Safety and Efficacy Register of New Interventional Procedures -Surgical (ASERNIP- S); 2002.
9. Patterson J. Outcomes of abdominoplasty. STEER: Succint and Timely Evaluated Evidence Reviews. Bazian Ltd., eds. London, UK: Wessex Institute for Health Research and Development, University of Southampton; 2003; 3(2):1-9.

10. Bragg TW, Jose RM, Srivastava S. Patient satisfaction following abdominoplasty: An NHS experience. J Plast Reconstr Aesthet Surg. 2007;60(1):75-78.
11. Graf R, de Araujo LR, Rippel R, et al. Lipoabdominoplasty: Liposuction with reduced undermining and traditional abdominal skin flap resection. Aesthetic Plast Surg. 2006;30(1):1-8.
12. Vila-Rovira R. Lipoabdominoplasty. Clin Plast Surg. 2008;35(1):95-104; discussion 105.
13. Heller JB, Teng E, Knoll BI, Persing J. Outcome analysis of combined lipoabdominoplasty versus conventional abdominoplasty. Plast Reconstr Surg. 2008;121(5):1821-1829.
14. Halbesma GJ, van der Lei B. The reverse abdominoplasty: A report of seven cases and a review of English-language literature. Ann Plast Surg. 2008;61(2):133-137.
15. A. Graf, K. Yang, K. Klement, N. Kim, H. Matloub. Abdominal suspension during massive panniculectomy: A novel technique and review of the literature. JPRAS Open. June 2016. https://doi.org/10.1016/j.jpra.2016.04.001. Accessed 18, September 2016.
16. Vincenzo Colabianchi, Giancarlo de Bernardinis, Matteo Giovannini, and Marika Langella, Panniculectomy Combined with Bariatric Surgery by Laparotomy: An Analysis of 325 Cases, Surgery Research and Practice, vol. 2015, Article ID 193670, 10 pages, 2015. doi:10.1155/2015/193670. Accessed 18 September 2017
17. ASPS Executive Committee: June 2017. American Society of Plastic Surgeons Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients.

***Note**:*
Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plan.

RightCare STAR Medicaid plans are offered through Scott and White Health Plan in the Central Managed Care Service Area (MRSA) and STAR and CHIP plans are offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSAs.