

## COSMETIC, RECONSTRUCTIVE AND RESTORATIVE SERVICES

(Formerly Cosmetic/Reconstructive Surgery)

**Number:** 200807-0001

**Effective Date:** 06/2000

**Revision Date:** 04/08/2008

### Overview

This policy addresses coverage for certain reconstructive, restorative and cosmetic services. All FCHP plans exclude coverage for cosmetic services.

Some services may be considered reconstructive or restorative when criteria are met and cosmetic when criteria are not met. For example, the excision of an asymptomatic, benign skin lesion is considered cosmetic and is not covered. If the lesion becomes symptomatic, excision may be medically necessary and may be covered.

In accordance with the Women's Health & Cancer Rights Act of 1998, breast reconstruction following mastectomy is covered, as are procedures of the contralateral breast to achieve symmetry. Refer to *Post-Mastectomy Surgery and Services* policy for coverage of services following mastectomy.

Please note that while this policy addresses many common surgeries, procedures, and treatments, it does not address all services that might be considered reconstructive, restorative or cosmetic. FCHP reserves the right to deny coverage for any other surgery, procedure, or treatment that FCHP determines to be cosmetic or not medically necessary.

### Definitions

**Reconstructive surgery** – a procedure performed to improve or correct a physical functional impairment resulting from a congenital defect or birth abnormality, accidental injury, prior surgical procedure or disease.

**Physical functional impairment** – a condition in which the normal or proper action of a body part is damaged. This may include, but is not limited to, problems with ambulation, communication, respiration, swallowing, vision, or skin integrity. A physical functional impairment affects the ability to participate in activities of daily living. A physical functional impairment does not include an individual's emotional well-being or mental health.

**Restorative surgery** – the initial procedure to repair or restore appearance that was damaged by an accidental injury. For example, the repair of a facial deformity following a serious automobile accident. The injury must have taken place on or after the plan member's effective date with FCHP.

**Cosmetic services** – a surgery, procedure or treatment that is performed primarily to reshape or improve the patient's appearance. Cosmetic services are not medically necessary, and are

not covered, whether intended to improve an individual's emotional well being or to treat a mental health condition.

**Deformity** – a permanent structural deviation from the normal shape or size, resulting in disfigurement.

**Plastic surgery** – is a medical specialty that uses surgical procedures to change or restore appearance and/or function of a person's body. Some plastic surgery procedures are cosmetic in nature and some are reconstructive.

## Covered Services

**Except where specifically indicated in the table below, all reconstructive and restorative services require preauthorization.**

**FCHP covers reconstructive surgery when the surgery can reasonably be expected to improve or correct a physical functional impairment resulting from a congenital defect or birth abnormality, accidental injury, prior surgical procedure, or disease.** The definition of reconstructive surgery is based on two distinct factors:

1. Whether the surgery is primarily indicated to improve or correct a physical functional impairment (the presence or absence of a physical functional impairment is a critical point in determining eligibility for coverage); and
2. What the etiology of the defect is (e.g., congenital defect or birth abnormality, accidental injury, prior surgical procedure, or disease).

In many instances, the concept of reconstructive overlaps with the concept of medically necessary.

**FCHP covers the restorative surgery to repair or restore appearance damaged by accidental injury.** Only the initial repair is covered. The injury must have taken place on or after the plan member's effective date. If a procedure is normally done in stages, with healing periods in-between, all stages are covered. (Note: Contract language may vary regarding coverage for restorative surgery. When no functional impairment is present, the etiology of the condition must be determined and the contract language reviewed to see if this etiology is included in the definition of restorative surgery.)

**Cosmetic surgery, cosmetic treatments, cosmetic procedures, cosmetic medications and cosmetic supplies are not covered (even when intended to improve self-esteem or treat a mental health condition).** In addition, **drugs, biologicals, facility/hospital charges, laboratory and radiology charges, and charges for surgeons, assistant surgeons, anesthesiologists, and any other incidental services which are directly related to the cosmetic surgery/procedure are not covered.** However, services required to treat a complication that arises as a result of a prior non-covered surgery/procedure, may be covered when medically necessary in all other respects.

There are separate medical policies that address the treatment of certain specific conditions or procedures that supersede this policy:

- Varicose Veins
- Orthognathic Surgery
- Surgery for Obstructive Sleep Apnea
- Temporomandibular Joint Disorder
- Post-Mastectomy Surgery and Services

- Phototherapy for Skin Conditions

The following services are covered when they are performed to improve or correct a physical functional impairment and when the surgery, procedure or treatment can reasonably be expected to improve or correct the physical functional impairment. When these services are performed to improve appearance in the absence of any signs and or symptoms of physical functional impairment, they are considered cosmetic and are not covered (with the exception of services performed to repair or restore appearance after accidental injury).

Surgery/Procedure	Medical Necessity Criteria
<b>Eyelid(s)</b>	
<p><b>Upper blepharoplasty</b> Upper blepharoplasty is a surgical procedure to remove redundant (excess) tissue from the upper eyelid(s).</p> <p><b>Blepharoptosis repair</b> Blepharoptosis (or ptosis) is the term used to describe drooping of one or both eyelids. Blepharoptosis repair is a surgical procedure performed on the levator muscle (the muscle that raises the upper eyelid) to correct a visual impairment caused by drooping of the eyelids.</p> <p>Upper blepharoplasty is a separate and distinct procedure from blepharoptosis repair. Certain patients may have a visual field obstruction caused by the combined effects of excessive eyelid tissue and eyelid drooping. Simultaneous upper blepharoplasty and ptosis repair may be medically necessary to provide functional improvement in these patients. When more than one procedure is requested, documentation that satisfies the criteria for each must be submitted.</p> <p><b>Hering’s Law</b> – Occasionally, when one upper eyelid is surgically repaired, the other eyelid malfunctions. Equal innervation is considered satisfactory documentation to perform a bilateral blepharoptosis repair when one upper eyelid has marginal criteria and the other eyelid meets criteria for repair.</p>	<p><b>Upper blepharoplasty may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To correct prosthesis difficulties associated with an anophthalmic socket.</li> <li>• To repair conditions causing corneal or conjunctival irritation, such as entropion, ectropion, pseudotrachiasis, or chronic dermatitis (caused by redundant eyelid tissue).</li> <li>• To treat periorbital sequelae of thyroid disease, facial paralysis, or nerve palsy that is causing a physical functional impairment, such as incomplete closure of the eye, and that has not resolved after adequate medical treatment.</li> <li>• To relieve painful symptoms (severe squinting secondary to uncontrollable spasms of the periorbital muscles) of primary essential idiopathic blepharospasm, when other treatments have failed.</li> <li>• To repair or restore appearance that was damaged by an accidental injury (only the initial restorative repair is covered).</li> </ul> <p><b>Upper blepharoplasty and/or blepharoptosis repair may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To remove excess upper eyelid tissue and/or repair a drooping eyelid causing a functional visual impairment when all the following criteria are met: <ol style="list-style-type: none"> <li>1. Documented visual complaints, such as difficulty reading, walking, or driving.</li> <li>2. Visual field testing that indicates a significant loss of superior visual field. Each eye should be tested with the upper eyelid at rest and repeated with the upper eyelid skin and/or eyelid</li> </ol> </li> </ul>

Surgery/Procedure	Medical Necessity Criteria
	<p>margin taped to demonstrate potential correction by the proposed procedure or procedures:</p> <ol style="list-style-type: none"> <li>a. Visual field obstruction by the eyelid at rest must limit the upper visual field to within 30 degrees measured from the central fixation point.</li> <li>b. The upper visual field must improve by at least 20 degrees with the redundant eyelid tissue and/or the upper eyelid taped (such that the eyelid margin assumes the anatomic position) to demonstrate potential correction by the proposed procedure or procedures.</li> </ol> <ol style="list-style-type: none"> <li>3. For upper blepharoplasty, frontal photographs demonstrating upper eyelid skin overhanging the upper eyelid margin and resting on the eyelashes. Lateral photographs may also be required to show redundant skin on the eyelashes.</li> </ol>
<p><b>Brow ptosis repair</b> Brow ptosis repair is a surgical procedure to tighten the muscular structures that support the eyebrow. Brow ptosis repair restores the eyebrow to its normal anatomic position.</p> <p>Brow ptosis repair may be performed alone or in combination with upper blepharoplasty and/or blepharoptosis repair. When more than one procedure is requested, documentation that satisfies the criteria for each must be submitted.</p>	<p><b>Brow ptosis repair may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To repair eyebrow drooping that is causing a functional visual impairment when all of the following criteria are met: <ol style="list-style-type: none"> <li>1. Documented visual complaints, such as difficulty reading, walking, or driving.</li> <li>2. Frontal photograph showing the position of the eyebrow below the supraorbital rim.</li> <li>3. Significant visual field impairment (30 degrees measured from the central fixation point) that cannot be corrected by upper blepharoplasty and/or blepharoptosis repair demonstrated with the upper eyelid at rest and with the upper eyelid taped.</li> </ol> </li> </ul>
<p><b>Lower blepharoplasty</b> Lower blepharoplasty is a surgical procedure to remove redundant lower eyelid tissue.</p> <p>Lower eyelid blepharoplasty is not generally indicated to treat conditions that cause visual field impairment.</p>	<p><b>Lower blepharoplasty may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To correct prosthesis difficulties associated with an anophthalmic socket.</li> <li>• To repair conditions causing corneal or conjunctival irritation, such as entropion, ectropion, pseudotrachiasis, or chronic dermatitis (caused by redundant eyelid</li> </ul>

Surgery/Procedure	Medical Necessity Criteria
	tissue). <ul style="list-style-type: none"> <li>To repair defects caused by trauma or tumor-ablative surgery.</li> <li>To treat periorbital sequelae of thyroid disease, facial paralysis, or nerve palsy that has not resolved after adequate medical treatment.</li> </ul>
<b>Nose</b>	
<b>Excision or surgical planing of rhinophyma</b> Rhinophyma is a condition of marked overgrowth of the sebaceous glands and fibrous tissue of the nose. The condition is thought to be associated with rosacea. Usually there is no functional physical impairment associated with rhinophyma and surgical treatment is considered ineligible for coverage on the basis of medical necessity. <sup>1</sup>	<b>Excision or shaving of rhinophyma may be medically necessary:</b> <ul style="list-style-type: none"> <li>To treat rhinophyma that is causing a nasal obstruction that is impairing respiratory function (obstructing rhinophyma).</li> </ul>
<b>Rhinoplasty</b> Rhinoplasty is a surgical procedure that is performed to change the shape and/or size of the nose or to correct a nasal defect.  Rhinoplasty is most often performed for cosmetic purposes.	<b>Rhinoplasty may be medically necessary:</b> <ul style="list-style-type: none"> <li>To repair a chronic, nasal obstruction that directly causes a significant and symptomatic airway compromise, secondary to a congenital defect, disease, or tumor-ablative surgery, when all of the following criteria are met:               <ol style="list-style-type: none"> <li>Photographic documentation (if there is an external nasal deformity) along with objective documentation that substantiates the severity of symptoms.</li> <li>There are no other identifiable causes, e.g., polyps, allergies, turbinate hypertrophy, septal defect, or chronic lung disease.</li> <li>Documentation that a reasonable trial of appropriate conservative treatment has failed.</li> <li>Septoplasty and/or turbinectomy alone would not be expected to resolve the condition.</li> </ol> </li> <li>To repair a nasal deformity secondary to cleft lip/palate or other congenital craniofacial deformity that is causing a physical functional impairment. In the absence of an airway obstruction, cleft rhinoplasty is usually delayed until the child</li> </ul>

<sup>1</sup> EOC language should be reviewed to determine whether excision or surgical planing for rhinophyma is eligible for coverage according to the definition of restorative surgery.

Surgery/Procedure	Medical Necessity Criteria
	<p>is about 16 years of age. (Primary nasal repair is usually done at the time of the primary cleft lip repair.)</p> <ul style="list-style-type: none"> <li>To repair or restore appearance that was damaged by an accidental injury (only the initial restorative repair is covered).</li> </ul>
<p><b>Septoplasty</b> Septoplasty is a surgical procedure performed to correct a deformity (or deviation) of the nasal septum. This is most often a functional surgery that repairs altered anatomy of the nasal septum and does not alter the external appearance of the nose. Septoplasty is sometimes referred to as submucous resection of the septum (SMR) or septal reconstruction.</p>	<p><b>Septoplasty may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>To repair a deviated, perforated, or deformed septum that directly causes a significant and symptomatic airway compromise, recurrent nose bleeds, or recurrent sinusitis, secondary to a congenital defect, disease, trauma, or tumor-ablative surgery, when all of the following criteria are met: <ol style="list-style-type: none"> <li>Objective documentation that substantiates the severity of symptoms. A deviated septum is readily apparent on a CT, however, obtaining a CT scan is not necessary in a patient in whom no other pathology is suspected (e.g., concomitant sinus disease).</li> <li>There are no other identifiable causes, e.g., polyps, allergies, turbinate hypertrophy, or chronic lung disease.</li> <li>Documentation that a reasonable trial of appropriate conservative treatment has failed, including the duration and dose of the actual treatments – antibiotics, nasal steroids.</li> </ol> </li> <li>For the treatment of headache of septal spur origin. Septal spur headache may be diagnosed when pain is relieved temporarily by topical anesthetics are applied to the septal impaction.</li> <li>To repair a nasal deformity secondary to cleft lip/palate or other congenital craniofacial deformity that is causing a physical functional impairment.</li> </ul>
<b>Ear(s)</b>	
<p><b>Otoplasty to correct protruding ears, with or without size reduction (CPT code 69300)</b> Otoplasty is a surgical procedure to correct large and/or protruding ears.</p>	<p><b>Otoplasty to correct protruding ears, with or without size reduction, is not a covered benefit.</b></p>
<p><b>Total external ear reconstruction</b> Total external ear reconstruction is usually</p>	<p><b>Total external ear reconstruction may be medically necessary:</b></p>

Surgery/Procedure	Medical Necessity Criteria
<p>performed in stages. Each stage is spaced several months apart to allow for healing.</p> <p>Total external ear reconstruction does not include reconstruction of the external auditory canal.</p>	<ul style="list-style-type: none"> <li>• To repair a congenital deformity (microtia<sup>2</sup>) of the external ear (auricle) when criterion 1 or 2 and 3 are met:               <ol style="list-style-type: none"> <li>1. Audiology evaluation and hearing testing document a significant hearing impairment and there is a likelihood that ear reconstruction will improve the hearing impairment.</li> <li>2. To facilitate the use of eyeglasses or a hearing aid.</li> <li>3. The patient has sufficient costal cartilage to carry out an optimal reconstruction. Generally, the costal cartilage is adequate by the time the patient is aged 9-10 years.</li> </ol> </li> <li>• To repair or restore appearance that was damaged by accidental injury (only the initial restorative repair is covered), when skin quality in the auricular area secondary to burns or scarring does not prevent satisfactory results.</li> </ul>
<p><b>Reconstruction of the external auditory canal</b></p>	<p><b>Reconstruction of the external auditory canal may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To repair congenital atresia that is causing a significant hearing loss, and there is a likelihood that the procedure will improve the hearing impairment</li> <li>• To repair a deformed (e.g., stenotic) external auditory canal caused by disease or previous surgery when a significant hearing loss is documented.</li> <li>• To repair or restore appearance that was damaged by accidental injury (only the</li> </ul>

<sup>2</sup> Microtia is a congenital malformation of variable severity of the external ear. It can be unilateral or bilateral. Microtia occurs in 1 out of about 8,000 to 10,000 births. Microtia is usually isolated, but may occur in conjunction with hemifacial microsomia or Treacher-Collins Syndrome. Aural atresia (malformation of the external auditory canal) is commonly associated with Grades III and IV microtia. However, congenital aural atresia may be found in the presence of a completely normal auricle. There are varying degrees of aural atresia, the ear canal may be completely absent, or there may be a blind sinus or tight stenosis leading to an abnormally small tympanic membrane.

- Grade 1 microtia is a slightly small ear with normal architecture and a patent external auditory canal.
- Grade 2 microtia is a partial or hemi-ear missing much of the normal architecture and is usually associated with a stenotic external auditory canal producing a conductive hearing loss.
- Grade 3 microtia is a residual vestige malpositioned lobule and is usually associated with atresia.
- Grade 4 microtia is the complete absence of an ear (anotia) and is usually associated with atresia.
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Surgery/Procedure	Medical Necessity Criteria
<p><b>Ear piercing</b> Ear piercing is cosmetic surgery.</p> <p>(Note: repair of traumatic tear or laceration of the ear or other body piercing is medically necessary.)</p>	<p>initial restorative repair is covered).</p> <p><b>Ear piercing is not a covered benefit.</b></p>
<b>Facial – includes the upper and lower jaws and the chin</b>	
<p><b>Rhytidectomy</b> Rhytidectomy is a surgical procedure to remove redundant (excess) skin from the facial area.</p> <p>This procedure is commonly known as a facelift.</p>	<p><b>Rhytidectomy may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To restore appearance that was damaged by accidental injury (only the initial restorative repair is covered).</li> <li>• To repair a physical functional impairment secondary to a congenital defect or birth abnormality, accidental injury, prior surgical procedure, or disease (e.g., facial paralysis or nerve palsy. A functional impairment may occur when excess skin impairs eating and drinking.</li> </ul>
<p><b>Repair of cleft lip with or without nasal deformity (cheiloplasty)</b> Cheiloplasty is a surgical procedure to repair a cleft in the lip. Almost all children with a complete cleft lip and many with an incomplete cleft lip will have an associated nasal deformity. Primary cheiloplasty for cleft lip includes repair of a nasal deformity. It is unusual for the nasal deformity to be totally corrected during the primary repair and secondary rhinoplasty is quite common.</p>	<p><b>Primary repair of cleft lip with or without a nasal deformity may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To repair a congenital cleft lip, with or without a nasal deformity, that is causing a physical functional impairment, such as difficulty eating or drinking. For safe repair under general anesthesia, it is recommended that the child be at least 10 weeks of age, weight 10 pounds or more, have an Hgb of at least 10g, and a WBC count less than 10,000/mm<sup>3</sup>.</li> </ul> <p><b>Secondary repair of cleft lip may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To revise a congenital cleft palate repair when there has been unfavorable healing, resulting in tightness or asymmetry. Secondary repair is accomplished by recreating the defect and closing it with a more satisfactory alignment.</li> </ul>
<p><b>Palatoplasty for cleft palate</b> A palatoplasty is a surgical procedure to repair a cleft in the soft and or hard palate. Primary palatoplasty is the initial cleft palate repair which is usually completed during the first year of life. Primary palatoplasty may be performed with or without soft tissue closure of alveolar ridge, and with or without bone</p>	<p><b>Primary palatoplasty may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To repair a congenital cleft palate that is causing a physical functional impairment. A cleft palate may impair feeding, speech impairments (hypernasal speech) and dental development.</li> </ul>

Surgery/Procedure	Medical Necessity Criteria
<p>graft (see <b>Maxillary alveolar cleft repair with bone graft</b> below).</p> <p>Sequelae of cleft lip and/or palate:</p> <ul style="list-style-type: none"> <li>• Nasolabial, oromaxillary, and/or oronasal fistula(s)</li> <li>• Maxillary alveolar ridge cleft</li> </ul>	<p><b>Secondary palatoplasty may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To repair a congenital cleft palate repair that is causing a physical functional impairment, such as velopharyngeal incompetence (hypernasal speech). Revision palatoplasty with pharyngeal flap repair should be done when it is absolutely clear that palate function is inadequate and speech has not improved with speech therapy. This flap can have a profound effect on breathing. Airway compromise in patients who undergo pharyngeal flap palatoplasty can be a potentially fatal complication.</li> </ul>
<p><b>Maxillary alveolar cleft repair with bone graft</b> Maxillary alveolar ridge cleft is a cleft of the dental ridge (gum line) of the upper jaw (maxilla) that commonly occurs in children with facial clefts.</p>	<p><b>Maxillary alveolar cleft ridge repair may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To repair a congenital maxillary alveolar cleft that is causing a physical functional impairment, such as, when the cleft impairs normal dental development.</li> </ul>
<p><b>Repair of nasolabial, oromaxillary, and/or oronasal fistula(s)</b> Some children with cleft palates, with or without cleft lips will be left with a fistula after the primary repair. In some cases, the fistula is left intentionally, in other cases it has developed because of poor healing.</p> <p>Fistulas may also be caused by infection, trauma or as a complication of removing a tooth.</p>	<p><b>Repair of nasolabial, oromaxillary, and/or oronasal fistula(s) may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To repair a fistula that is causing a physical functional impairment, such as difficulty eating or drinking or when the fistula impairs speech.</li> </ul>
<p><b>Mentoplasty</b> Mentoplasty refers to plastic surgery procedures for the chin.</p>	<p><b>Mentoplasty may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To repair or restore appearance that was damaged by accidental injury (only the initial restorative repair is covered).</li> <li>• To improve or correct a physical functional impairment (the ability to speak or chew normally) resulting from a congenital defect or birth abnormality, accidental injury, prior surgical procedure or disease. Dental history and x-rays of the head and jaw are necessary in order to determine whether the impairment can be corrected by a chin implant, augmentation or reduction.</li> <li>• In conjunction with a covered orthognathic surgery to correct deformities of the jaw.</li> </ul>

Surgery/Procedure	Medical Necessity Criteria
<p><b>Repair of craniofacial deformities</b> Surgical repair of skull (cranium) and facial deformities is referred to as craniofacial reconstruction. Craniofacial reconstruction includes a wide range of procedures, including, but not limited to, LeFort procedures, osteotomies, osteoplasties, and bone grafts, to the skull, forehead, midface, maxilla and/or mandible.</p> <p>Orthognathic surgery is a subset of craniofacial procedures mainly performed by an oral and maxillofacial surgeon almost always in conjunction with orthodontic treatment (such as malocclusion of the jaw).</p>	<p><b>Repair of craniofacial deformities may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To repair or restore appearance that was damaged by accidental injury (only the initial restorative repair is covered).</li> <li>• To improve or correct a physical functional impairment, resulting from a congenital defect or birth abnormality, accidental injury, prior surgical procedure or disease.</li> </ul>
<b>Chest</b>	
<p>In accordance with the Women’s Health &amp; Cancer Rights Act of 1998, breast reconstruction following mastectomy is covered, as are procedures of the contralateral breast to achieve symmetry. Refer to <i>Post-Mastectomy Surgery and Services</i> policy for coverage of services following mastectomy.</p>	
<p><b>Mammoplasty</b> There are three general categories of mammoplasty (i.e., plastic surgery performed on the breasts):</p> <ul style="list-style-type: none"> <li>• Augmentation mammoplasty</li> <li>• Reduction mammoplasty</li> <li>• Breast reconstruction</li> </ul> <p><u>Augmentation mammoplasty</u> is a surgical procedure in which the breasts are augmented or enlarged, usually with implants placed under or over chest muscle.</p> <p><u>Reduction mammoplasty</u> is a surgical procedure in which excess breast tissue is excised.</p> <p><u>Breast reconstruction</u> surgery may be performed when a breast has been disfigured due to trauma or following mastectomy. This procedure recreates a breast with the desired appearance.</p>	<p><b>Augmentation mammoplasty is not a covered benefit (except following a mastectomy – refer to <i>Post-Mastectomy Surgery and Services</i> policy for additional information).</b></p> <p><b>Reduction mammoplasty may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To relieve a physical functional impairment caused by hypertrophic breasts when all of the following criteria are met: <ol style="list-style-type: none"> <li>1. The patient is 16 years of age or older and has reached physical maturity.</li> <li>2. There is a reasonable likelihood that the member’s symptoms are primarily due to macromastia and reduction mammoplasty is likely to result in improvement of symptoms.</li> <li>3. The patient has significant symptoms that have interfered with activities of daily living, despite conservative management, for at least six months, including at least one of the following: <ol style="list-style-type: none"> <li>a. Back and/or shoulder pain unrelieved by conservative measures including analgesia (e.g., NSAIDs, compresses, etc.), supportive garments, physical therapy, and</li> </ol> </li> </ol> </li> </ul>

Surgery/Procedure	Medical Necessity Criteria
	<p>correction of obesity (defined as BMI &gt; 35)</p> <p>b. Significant, symptomatic arthritic changes (signs and symptoms of ulnar paresthesias, cervicalgia, torticollis or kyphosis) in the cervical or upper thoracic spine</p> <p>c. Intertriginous maceration or infection of the inframammary skin, refractory to dermatologic measures</p> <p>d. Shoulder grooving with skin irritation (areas of excoriation and breakdown) by appropriate supporting garment</p> <p>4. To be considered non-cosmetic, it is expected that at least a minimal amount of breast tissue will be removed. There are wide variations in the range of height, weight, and breast size that will cause symptoms and the amount of tissue that must be removed in order to relieve symptoms will vary. The following are FCHP medical criteria that address the anticipated amount of breast tissue to be excised:</p> <ul style="list-style-type: none"> <li>• 95-119 lbs. ⇒ 300 g excised per breast</li> <li>• 110-130 lbs. ⇒ 400 g excised per breast</li> <li>• 130+ lbs. ⇒ 500 g excised per breast</li> </ul> <p><b>Breast reconstruction may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To repair or restore appearance of a breast that was damaged by accidental injury (only the initial restorative repair is covered).</li> <li>• To repair or restore appearance of one or both breasts following a covered prophylactic mastectomy.</li> </ul>
<p><b>Removal of breast implants</b> Breast implants do not last a lifetime and will likely need to be removed either because of rupture, capsular contracture, or other complications.</p> <p>There are two main types of breast implants:</p> <ul style="list-style-type: none"> <li>• Saline-filled breast implants</li> </ul>	<p><b>Removal of either a silicone gel-filled breast implant or a saline-filled breast implant may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To facilitate the treatment of breast cancer</li> <li>• For the treatment of persistent or recurrent local or systemic infection, secondary to a breast implant, that is refractory to medical management</li> </ul>

Surgery/Procedure	Medical Necessity Criteria
<ul style="list-style-type: none"> <li>Silicone gel-filled breast implants</li> </ul> <p>Both types of breast implants have a silicone rubber protective shell (capsule).</p> <p><b>It is not medically necessary to remove a ruptured saline-filled breast implant, in the absence of other signs or symptoms (e.g., significant capsular contracture or persistent infection).</b></p>	<p>including antibiotics.</p> <ul style="list-style-type: none"> <li>For the treatment of <i>Baker Grade IV Capsular Contracture</i><sup>3</sup> that is causing pain, persistent infection refractory to medical management, or is interfering with preventive breast cancer screening.</li> </ul> <p><b>Removal of a ruptured silicone gel-filled breast implant (intracapsular or extracapsular rupture) that has been confirmed with MRI or other conclusive imaging study is medically necessary.</b></p> <p>Note: When criteria for removal of a breast implant are met unilaterally, removal of the implant in the contralateral breast is covered as long as both implants are removed at the same time.</p> <p>Even when removal of breast implants meets medical necessity criteria, reinsertion of replacement breast implants is considered cosmetic and is not covered (unless the original implants were inserted following a medically necessary mastectomy – refer to <i>Post-Mastectomy Surgery and Services</i> policy for additional information).</p>
<p><b>Mastectomy for gynecomastia</b></p> <p>The male breast contains both glandular and fatty tissue. Gynecomastia results from proliferation of glandular tissue. The proliferation of only fatty tissue is known as pseudogynecomastia.</p> <p>Gynecomastia occurs most frequently during times of male hormonal changes, resulting from the effect of an altered estrogen/androgen balance, in favor of estrogen, on breast tissue. The majority of patients with gynecomastia require no</p>	<p><b>Mastectomy for gynecomastia may be medically necessary when:</b></p> <ul style="list-style-type: none"> <li>The patient is 17 years of age or older, has been diagnosed with gynecomastia on physical examination, and the gynecomastia and its associated signs and symptoms have been followed and documented by a physician over at least a 12-month period, AND</li> <li>The patient has had a consult with an endocrinologist to identify and treat or correct any underlying causes, AND</li> <li>Despite treatment or correction of any</li> </ul>

<sup>3</sup> Capsular contracture occurs when the scar tissue that normally forms around the implant tightens and squeezes the implant. It can happen to one or both of the implanted breasts. There are four grades of capsular contracture, known as Baker grades I through IV. The Baker grading is as follows:

- Grade I the breast is normally soft and looks natural
- Grade II the breast is a little firm but looks normal
- Grade III the breast is firm and looks abnormal
- Grade IV the breast is hard, painful, and looks abnormal.

Surgery/Procedure	Medical Necessity Criteria
<p>treatment other than removal of the precipitating cause.</p> <p>Pseudogynecomastia is common in obese men and is differentiated from true gynecomastia by the presence of increased subareolar fat without enlargement of the breast glandular component.</p>	<p>underlying causes, gynecomastia and signs/symptoms have persisted for greater than 12 months with no evidence of reversal; AND</p> <ul style="list-style-type: none"> <li>• Patient has persistent subareolar pain documented in the medical record, which is refractory to analgesics and has a clinically significant impact upon activities of daily living, AND</li> <li>• Preoperative photographs are provided.</li> </ul>
<p><b>Mastopexy</b> Mastopexy or breast lift surgery refers to a surgical procedure designed to lessen the degree of breast ptosis (sagging).</p>	<p><b>Mastopexy is not a covered benefit (except following a mastectomy – refer to <i>Post-Mastectomy Surgery and Services</i> policy for additional information).</b></p>
<p><b>Prophylactic mastectomy</b> Prophylactic (preventive) mastectomy is the surgical removal of one or both breasts to prevent or reduce the risk of breast cancer.</p> <p>There are two surgical procedures for prophylactic mastectomy: total (simple) mastectomy or subcutaneous mastectomy. Neither procedure completely removes all breast tissue nor is the risk for breast cancer is completely eliminated.</p>	<p><b>Prophylactic mastectomy may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To prevent or reduce the risk of breast cancer in a female patient with a known BRCA1 or BRCA2 mutation confirmed by genetic testing.</li> <li>• To prevent or reduce the risk of breast cancer in a female patient who has a first or second-degree relative<sup>4</sup> with a known BRCA1 or BRCA2 mutation confirmed by genetic testing.</li> <li>• To prevent or reduce the risk of recurrent breast cancer in a male or female patient with a personal history of breast cancer.</li> <li>• To prevent or reduce the risk of breast cancer in a female patient with a personal history of ovarian cancer</li> </ul>
<p><b>Congenital chest wall deformities</b> Congenital chest wall deformities arise from abnormal development of the sternum, the costal cartilages, and the ribs. Such defects include pectus excavatum, pectus carinatum, and Poland syndrome (absence of the breast and the underlying pectoralis muscle and ribs). Of these, pectus excavatum is by far the most common, accounting for more than</p>	<p><b>Surgical repair of pectus excavatum may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• When the Haller Index<sup>5</sup> (transverse chest to narrowest anteroposterior diameter) is 3.25 or higher.</li> </ul> <p><b>Surgical repair of pectus carinatum may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• When a rigid or restrictive chest wall</li> </ul>

<sup>4</sup> A first degree relative is defined as a blood relative with whom an individual shares approximately 50% of his/her genes. A second degree relative is defined as a blood relative with whom an individual shares approximately 25% of his/her genes.

<sup>5</sup> A generally agreed upon, objective measurement of the severity of pectus excavatum is the Haller index. A normal value is 2.5, and a Haller index of greater than 3.25 represents the degree of deformity for which surgery is recommended.

Surgery/Procedure	Medical Necessity Criteria
<p>90% of all congenital chest wall procedures.</p>	<p>results in less than optimal respiration, such as incomplete expiration, or exertional dsypnea. Pulmonary function testing may be useful to determine the impact of the deformity on the performance of the heart and lungs (affected individuals may not be aware of the gradual decrease in exercise tolerance that occurs over time).</p> <p><b>Surgical repair of Poland syndrome may be considered medically necessary:</b></p> <ul style="list-style-type: none"> <li>To repair a physical functional impairment secondary to a chest wall deformity. The most frequent indication for reconstructive surgery is severe chest asymmetry in which the chest viscera are exposed and susceptible to trauma. Costal aplasia or hypoplasia without physical functional impairment (such as respiratory compromise or exercise intolerance) is not an indication for repair.</li> </ul>
<p><b>Surgical repair of inverted nipple</b>            Inverted nipple is defined as a nipple located on a plane lower than the areola. Nipple inversion is categorized according to severity, with Grade III being the most severe. Grades I and II rarely impair breast feeding. Grade III may impair breast feeding; however, surgical repair does not consistently restore functionality, i.e., the ability to breast feed.</p>	<p><b>Surgical repair of inverted nipple may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>To repair an inverted nipple that is causing a physical functional impairment, i.e., the inability to breast feed, and the procedure can be reasonably expected to restore functionality. It is not possible to know whether or not an inverted nipple will impair breast feeding until breast feeding has been attempted.</li> </ul>
<b>Abdomen</b>	
<p><b>Panniculectomy</b>            Panniculectomy is the surgical excision of redundant (excess) hanging abdominal skin and fat (panniculus) but does not include muscle plication or neoumbilicoplasty as in an abdominoplasty.</p> <p>Panniculectomy is not covered when performed as an adjunct to other medically necessary procedures such as, hysterectomy or ventral/incisional hernia repair unless the criteria for panniculectomy are independently met.</p>	<p><b>Panniculectomy may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>In cases where the panniculus hangs below the level of the pubis (photographic documentation is required), AND</li> <li>The panniculus is the result of weight loss, AND</li> <li>Weight loss of at least 75 pounds has been sustained for at least six months (AND if weight loss is the result of bariatric surgery, panniculectomy is not covered until at least 18 months after bariatric surgery), AND</li> <li>It is documented in the patient's medical record that the panniculus directly impairs</li> </ul>

Surgery/Procedure	Medical Necessity Criteria
	physical function, i.e., the panniculus: <ul style="list-style-type: none"> <li>- Interferes with ambulation, urination or other activities of daily living, or</li> <li>- Causes recurring persistent intertriginous rashes, ulcerations, and/or infections that develop in the abdominopelvic fold (panniculitis) and that are refractory to good personal hygiene and documented optimal medical management including local and systemic medications.</li> </ul>
<p><b>Abdominoplasty</b>            Abdominoplasty is a surgical procedure which includes the excision of skin and subcutaneous fat in the abdomen, plus a range of secondary nonfunctional procedures such as transposition of the umbilicus, repair of lax abdominal muscles and suction assisted liposuction. This 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.</p> <p>Panniculectomy and abdominoplasty are often performed together to achieve the best cosmetic result. (Abdominoplasty is an add-on procedure that cannot be billed alone.)</p>	<p><b>Abdominoplasty is not a covered benefit.</b></p>
<p><b>Diastasis recti abdominis repair</b>            Diastasis recti abdominis is the separation of the left and right side of the rectus abdominis muscle. Diastasis recti abdominis occurs primarily in pregnant women and newborns, but may also occur in patients with chronic obstructive pulmonary disease, following abdominal surgery, or with obesity.</p>	<p><b>Diastasis recti abdominis repair may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• If a hernia develops and becomes trapped in the space between the muscles. The recti abdominis muscle may be repaired at the time of the hernia repair to prevent recurrence.</li> </ul>
<b>Skin</b>	
<p><b>Tattooing</b>            The introduction of insoluble pigments to correct color defects of the skin.</p> <p>Tattooing is not separately reimbursable in conjunction with radiation therapy.</p> <p><b>Tattooing is considered cosmetic (i.e., not medically necessary) for the treatment of vitiligo because it does not treat the</b></p>	<p><b>Tattooing may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To give the nipple-areola complex a more natural appearance following breast reconstruction surgery.</li> <li>• To repair or restore appearance of skin (scar or burn camouflage) that has been damaged by accidental injury (only the initial restorative repair is covered).</li> </ul>

Surgery/Procedure	Medical Necessity Criteria
<p><b>underlying condition or result in improved protection against skin cancer.</b></p>	
<p><b>Tattoo removal</b>  The removal of tattoos is attempted with laser treatments, abrasion, or dermabrasion. Multiple treatments may be needed and results will vary depending on the size of the tattoo and the color and quality of the ink used. Some tattoos cannot be completely removed and some treatments may cause scarring.</p> <p><b>Removal of a decorative tattoo is not covered.</b></p>	<p><b>Tattoo removal may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To remove a positional tattoo placed to facilitate radiation therapy. (See <b>Abrasion</b> below.)</li> </ul>
<p><b>Scar revision</b>  The timing of scar revision is variable. Most scars will show some improvement for up to 1 to 3 years without revision. A scar that is uneven, shows a marked step-off, or is obviously poorly positioned may be revised as early as 2 months after the original closure. If it is possible to tell early that a scar will not improve with maturation, there is not a compelling reason to make the patient wait. In fact, early revision with realignment of the scar may allow it to mature more rapidly.</p> <p>Several techniques can minimize a scar however no scar can ever be completely removed. FCHP covers the following scar revision techniques:</p> <ul style="list-style-type: none"> <li>• Tissue transfer, i.e., flaps and grafts</li> <li>• Scar reexcision</li> <li>• Scar rearrangement (i.e., Z-plasty, W-plasty)</li> <li>• Abrasion or dermabrasion</li> <li>• Pulsed dye laser</li> <li>• Intralesional corticosteroid injections</li> </ul>	<p><b>Scar revision may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• When the scar is the result of accidental injury (the injury must have taken place on or after the plan member's effective date with FCHP), or</li> <li>• When the scar causes a physical functional impairment, i.e., the scar interferes with the movement of a joint, or when the scar is associated with symptoms of intense pain, burning, or itching that cannot be effectively treated with local and or systemic medication, such as analgesics, corticosteroids or antibiotics, or</li> <li>• When the scar has a history of intermittent breakdown.</li> </ul>
<p><b>Intralesional corticosteroid injections</b>  Intralesional corticosteroid injections are used alone or in combination with other therapeutic modalities in the treatment of many skin diseases. The purpose of the injection is to attain a high concentration of the drug at the diseased site, with minimal systemic absorption.</p>	<p><b>Intralesional corticosteroid injections may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To treat a painful neuroma (scar infiltration), or</li> <li>• To treat symptomatic inflammatory or infiltrating skin lesions (i.e., the lesion is inflamed, irritated, or infected, and there is bleeding, intense itching, pain, oozing, erythema, or purulence), or</li> <li>• To treat a scar that has become</li> </ul>

Surgery/Procedure	Medical Necessity Criteria
	<p>symptomatic, impairs physical function or is the result of an accidental injury (the injury must have taken place on or after the plan member's effective date with FCHP).</p> <p><b>Intralesional corticosteroid injections (CPT codes 11900-11901) do not require preauthorization.<sup>6</sup></b></p>
<p><b>Skin tag removal</b> Skin tag removal by any method, includes local anesthesia and simple closure. Repair by intermediate or complex closure is reported separately.</p> <p>In the majority of cases, skin tags are asymptomatic and require no intervention. Patients often seek treatment because of the unsightly appearance of skin tags, requesting removal solely for cosmetic purposes. <b>Removal of asymptomatic skin tags is considered not medically necessary and is not covered.</b></p> <p>In rare situations, skin tags may become symptomatic and medical or surgical intervention would be indicated.</p>	<p><b>Removal of skin tags may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>When the skin tag becomes symptomatic, such as such as when the skin tag is in a location that causes it to be subject to repeated irritation/trauma and the skin tag is inflamed, irritated, or infected, and there is bleeding, intense itching, pain, oozing, erythema, or purulence.</li> </ul> <p><b>Removal of skin tags (CPT codes 11200-11201) does not require preauthorization.<sup>7</sup></b></p>
<p><b>Shaving of epidermal or dermal lesions</b> Shaving includes local anesthesia. The resulting wound does not require suture closure. Shaving is used most commonly for the removal of moles (nevi).</p> <p><b>Shaving of a benign, asymptomatic epidermal or dermal lesion is considered not</b></p>	<p><b>Shaving of epidermal or dermal lesions may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>When the epidermal or dermal lesion becomes symptomatic, such as when the lesion is in a location that causes it to be subject to repeated irritation/trauma and the lesion is inflamed, irritated, or infected, and there is bleeding, intense itching, pain,</li> </ul>

<sup>6</sup> FCHP identifies services that are typically cosmetic and periodically reviews paid claims for these services. Medical records maintained by the provider must clearly document the symptoms and specific physical findings (e.g., painful inflamed acne cyst) that justifies intralesional corticosteroid injection and demonstrates compliance with this medical policy. The statement "irritated skin lesion" will not suffice for justification for intralesional corticosteroid injection. If documentation in the medical record does not support the medical necessity of an intralesional corticosteroid injectin FCHP will request repayment from the provider.

<sup>7</sup> FCHP identifies services that are typically cosmetic and periodically reviews paid claims for these procedures. Medical records maintained by the provider must clearly document the symptoms and specific physical findings (e.g., bleeding from clothing irritation) that justify the removal of skin tags and demonstrate compliance with this medical policy. The statement "irritated skin tag" will not suffice for justification for skin tag removal. If documentation in the medical record does not support the medical necessity of the removal of skin tags FCHP will request repayment from the provider.

Surgery/Procedure	Medical Necessity Criteria
<p><b>medically necessary and is not covered.</b></p>	<p>oozing, erythema, or purulence.</p> <ul style="list-style-type: none"> <li>• When the lesion obstructs an orifice or interferes with eye function. For example, periocular warts associated with chronic recurrent conjunctivitis.</li> <li>• When there is clinical uncertainty as to the likely diagnosis and where malignancy is a consideration based on the appearance of the lesion (evidenced by pathology submission)</li> <li>• When a prior biopsy suggests or is indicative of a malignancy.</li> </ul> <p><b>Shaving of epidermal or dermal lesions (CPT codes 11300-11313) does not require preauthorization.<sup>8</sup></b></p>
<p><b>Excision, benign skin lesion including margins, except skin tag</b> Excision is the full-thickness (i.e., through the dermis) removal of a lesion, and includes local anesthesia and simple closure. Each lesion removed is reported separately. Repair by intermediate or complex closure is reported separately.</p> <p>Benign skin lesions are common and include seborrheic keratoses, sebaceous cysts, lipomas, moles (nevi), and warts. <b>Removal of benign asymptomatic skin lesions is considered not medically necessary and is not covered.</b></p> <p>In rare situations, a benign skin lesion may become symptomatic and medical or surgical intervention would be indicated.</p>	<p><b>Excision of benign skin lesions may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• When the benign skin lesion becomes symptomatic, such as when the lesion is in a location that causes it to be subject to repeated irritation/trauma and the lesion is inflamed, irritated, or infected, and there is bleeding, intense itching, pain, oozing, erythema, or purulence.</li> <li>• When the lesion obstructs an orifice or interferes with eye function. For example, periocular warts associated with chronic recurrent conjunctivitis.</li> <li>• When there is clinical uncertainty as to the likely diagnosis and where malignancy is a consideration based on the appearance of the lesion (evidenced by pathology submission).<sup>9</sup></li> <li>• When a prior biopsy suggests or is indicative of a malignancy.</li> </ul>

<sup>8</sup> FCHP identifies services that are typically cosmetic and periodically reviews paid claims for these services. Medical records maintained by the provider must clearly document the symptoms and specific physical findings (e.g., bleeding from repeated irritation) that justify shaving of epidermal and dermal lesions and demonstrate compliance with this medical policy. The statement "irritated skin lesion" will not suffice for justification for shaving of an epidermal or dermal lesion. If documentation in the medical record does not support the medical necessity of shaving an epidermal or dermal lesion FCHP will request repayment from the provider.

<sup>9</sup> The decision to submit a specimen for pathologic interpretation will be independent of the decision to remove or not remove a lesion. Tissue diagnosis will be part of the medical record when a benign lesion is removed based on uncertainty as to the final clinical diagnosis.

Surgery/Procedure	Medical Necessity Criteria
<p>Note: When a lipoma is excised from deep subfascial or muscular tissue, CPT code 21930 may more appropriately describe the procedure.</p>	<p><b>Excision of benign skin lesions (CPT codes 11400-11446) does not require preauthorization.</b><sup>10</sup></p>
<p><b>Excision of redundant (excess) skin and subcutaneous tissue of the thighs, hips, buttocks, arms, or other anatomical areas</b></p> <p>(See Panniculectomy for excision of redundant skin and subcutaneous tissue of the abdomen)</p> <p>Removal of redundant skin, for any reason, including massive weight loss due to bariatric surgery, when there is not a functional physical impairment, is considered cosmetic. Excess skin is an expected outcome after weight loss.</p>	<p><b>Excision of redundant (excess) skin and subcutaneous tissue of the thighs, hips, buttocks, arms, or other anatomical areas, may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• In cases where the redundant skin is the result of weight loss of greater than 75 pounds, the weight loss has been sustained for at least six months (AND if weight loss is the result of bariatric surgery, excision of redundant skin is not covered until at least 18 months after bariatric surgery), AND</li> <li>• It is documented in the patient’s medical record that the redundant skin directly causes a physical functional impairment; i.e., the redundant skin: <ul style="list-style-type: none"> <li>– Interferes with mobility, urination, or other activities of daily living, or</li> <li>– Causes recurring persistent intertriginous rashes, ulcerations, and/or infections that are refractory to good personal hygiene and documented optimal medical management including local and systemic medications, AND</li> </ul> </li> <li>• The redundant skin is documented in photographs</li> </ul>
<p><b>Subcutaneous injection of filling material</b></p> <p>Injections of filling material, such as bovine collagen, are used to raise, or fill in, sunken scars. The results of collagen injections are immediate but temporary. The scars will eventually have to be re-filled as the body slowly absorbs the collagen.</p>	<p><b>Subcutaneous injection of filling material may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To repair a distensible scar, when the scar itself is the result of an accidental injury. A distensible scar is one that elevates to the surface when tension is placed on either side. (This test will allow the clinician to determine whether the particular scar will</li> </ul>

<sup>10</sup> FCHP identifies services that are typically cosmetic and periodically reviews paid claims for these services. Medical records maintained by the provider must clearly document the symptoms and specific physical findings (e.g., bleeding from repeated irritation) that justify the removal of a benign skin lesion and demonstrates compliance with this medical policy. The statement “irritated skin lesion” will not suffice for justification for the excision of a benign skin lesion. If documentation in the medical record does not support the medical necessity of the excision of a benign skin lesion FCHP will request repayment from the provider.

Surgery/Procedure	Medical Necessity Criteria
<p><b>Injection of filling materials is not covered for the treatment of acne or chicken pox scars, facial wrinkles or other cosmetic purposes.</b></p>	<p>likely respond to filling material. Placing filling material in a fibrotic or fixed scar will elevate the surrounding skin, producing a donut effect and making the scar appear worse.)</p>
<p><b>Chemical peel</b> Chemical peeling, also known as chemical exfoliation, is the process of applying chemicals to the skin to destroy the outer damaged layer(s). A chemical peel produces a controlled partial thickness injury to the skin. Different agents and formulations are used depending on the depth of the peel. Chemical peels are categorized as superficial, medium, and deep peels.</p> <p>Destruction of the epidermis defines a superficial chemical peel inducing the regeneration of the epidermis. An epidermal peel may be used to remove fine, subtle lines, soften the appearance of enlarged pores, improve skin texture, treat active acne, and lighten hyperpigmentation. <b>Epidermal peels are considered cosmetic and not covered.</b></p> <p>Dermal peel may be used to treat deep wrinkles, acne and chicken pox scars, or pre-cancerous actinic keratoses. <b>When used to treat wrinkles, acne or chicken pox, dermal peel is cosmetic and not covered.</b></p>	<p><b>Chemical peels (dermal and epidermal) are not covered.</b></p> <p>Note: Dermal peel may be used to remove large numbers of actinic keratoses (more than 10), when it is impractical to treat each lesion separately, and where there is a record of conventional methods, including cryosurgery, and topical medications, such as 5-fluorouracil, having been proved unsuccessful (unless contraindicated). However, destruction of actinic keratoses has its own set of CPT codes (17000-17004). See <b>Destruction pre-malignant lesions</b> below.</p>
<p><b>Destruction of premalignant lesions (e.g., actinic keratoses)</b> Destruction means the removal by any method, includes local anesthesia, and not usually requiring closure. Any method includes electrosurgery, cryosurgery, laser or chemical treatment.</p>	<p><b>Destruction of pre-malignant lesions (e.g., actinic keratoses) is medically necessary:</b></p> <ul style="list-style-type: none"> <li>To reduce the risk of development of metastatic squamous cell carcinoma.</li> </ul> <p><b>Destruction of actinic keratoses does not require preauthorization (CPT codes 17000-17004).</b></p>
<p><b>Destruction of cutaneous vascular lesions (e.g., hemangiomas, port wine stains)</b> Destruction means the removal by any method, includes local anesthesia, and not usually requiring closure. Any method includes electrosurgery, cryosurgery, laser or chemical treatment.</p> <p>Vascular cutaneous lesions are among the</p>	<p><b>Destruction of hemangiomas (by any method) may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>When the hemangioma is causing a functional impairment, including hemangiomas associated with ulcerations (e.g., perineal hemangiomas), impaired vision and astigmatism (e.g., eyelid or periorbital hemangiomas), auditory impairment and secondary speech delay</li> </ul>

Surgery/Procedure	Medical Necessity Criteria
<p>most common congenital abnormalities observed in infants and children. Vascular cutaneous lesions can be divided into those that are proliferative (hemangiomas) and those that are not proliferative (vascular malformations, such as salmon patch and port wine stain).</p> <p>These types of lesions commonly take up a large surface area of the patient's skin and therefore are measured in square centimeters.</p>	<p>(e.g., hemangiomas on the ear).</p> <ul style="list-style-type: none"> <li>• When the hemangiomas is symptomatic, e.g., subject to recurrent bleeding or infection, or pedunculated</li> <li>• When the hemangiomas is associated with Kasabach-Merritt syndrome.</li> </ul> <p><b>Laser treatment of port wine stains may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To treat port wine stains of the face and neck</li> <li>• When the port wine stain is symptomatic, e.g., subject to recurrent bleeding or infection</li> <li>• To prevent glaucoma, retinal detachment, and/or mental retardation due to involvement of the vasculature of the eye and CNS (typically associated with Sturge-Weber syndrome).</li> </ul>
<p><b>Destruction of benign lesions other than skin tags or cutaneous vascular lesions</b> Destruction means the removal by any method, includes local anesthesia, and not usually requiring closure. Any method includes electrosurgery, cryosurgery, laser or chemical treatment.</p> <p>Benign skin lesions are common and include seborrheic keratoses, sebaceous cysts, lipomas, moles (nevi), and warts. <b>Removal of benign asymptomatic skin lesions is considered not medically necessary and is not covered.</b></p> <p>In rare situations, a benign skin lesion may become symptomatic and medical or surgical intervention would be indicated.</p>	<p><b>Destruction of benign lesions other than skin tags or cutaneous vascular lesions may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• When the benign skin lesion becomes symptomatic, such as when the lesion is in a location that causes it to be subject to repeated irritation/trauma and the lesion is inflamed, irritated, or infected, and there is bleeding, intense itching, pain, oozing, erythema, or purulence.</li> <li>• When the lesion obstructs an orifice or interferes with eye function. For example, periocular warts associated with chronic recurrent conjunctivitis.</li> <li>• When there is clinical uncertainty as to the likely diagnosis and where malignancy is a consideration based on the appearance of the lesion (evidenced by pathology submission).</li> <li>• When a prior biopsy suggests or is indicative of a malignancy.</li> </ul> <p><b>Destruction of benign skin lesions (CPT codes 17110-17111) does not require preauthorization.<sup>11</sup></b></p>

<sup>11</sup> FCHP identifies services that are typically cosmetic and periodically reviews paid claims for these procedures. Medical records maintained by the provider must clearly document the symptoms and specific physical findings (e.g., bleeding from repeated irritation) that justify destruction of benign skin

Surgery/Procedure	Medical Necessity Criteria
<p><b>Abrasion</b> Abrasion may be performed to improve the appearance of one or more small, isolated scars. Techniques vary and may include a high-speed rotary abrasive instrument, fine-grit sandpaper, laser, or a curette.</p>	<p><b>Abrasion may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To improve the appearance of a small scar that is the result of an accidental injury (restorative).</li> <li>• To remove a positional tattoo placed to facilitate radiation therapy.</li> </ul>
<p><b>Dermabrasion</b> Dermabrasion may be performed to improve the appearance of a scar or large areas of scarring. Techniques vary and may include a high-speed rotary abrasive instrument, fine-grit sandpaper, CO<sub>2</sub> or YAG laser, or a curette.</p> <p>Dermabrasion may be performed following other scar revision techniques, such as, running Z-plasty, or W-plasty, to better blend the new scar with the surrounding skin.</p> <p><b>Dermabrasion for removal of acne, or acne or chicken pox scars is considered cosmetic and not medically necessary.</b></p>	<p><b>Dermabrasion may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To improve the appearance of a large scar or a large area of scarring that is the result of an accidental injury (restorative).</li> <li>• To remove a positional tattoo placed to facilitate radiation therapy.</li> </ul> <p>Note: Dermabrasion may be considered medically necessary to remove large numbers of actinic keratoses (more than 10), when it is impractical to treat each lesion separately, and where there is a record of conventional methods, including cryosurgery, and topical medications, such as 5-fluorouracil, having been proved unsuccessful (unless contraindicated). However, destruction of actinic keratoses has its own CPT codes (17000-17004). See <b>Destruction pre-malignant lesions</b> above.</p>
<b>Hair</b>	
<p><b>Hair transplant</b> Hair may be transplanted from the scalp or other hair-containing tissue to an area devoid of hair by either strip graft (CPT codes 15220 and 15221) or punch graft (CPT codes 15775 and 15776).</p> <p><b>Hair transplant performed to correct male pattern baldness, age-related hair thinning, baldness (alopecia) due to disease, previous therapy, or congenital scalp disorders is cosmetic and not covered.</b></p>	<p><b>Hair transplant may be medically necessary:</b></p> <ul style="list-style-type: none"> <li>• To improve the appearance of a scar in the scalp that is the result of an accidental injury (restorative).</li> </ul>
<p><b>Hair removal</b></p> <p><b>Hair removal, by any method, temporary or permanent, including, but not limited to,</b></p>	<p><b>Hair removal is not covered.</b></p>

lesions and demonstrate compliance with this medical policy. The statement "irritated skin lesion" will not suffice for justification for destruction of benign skin lesions. If documentation in the medical record does not support the medical necessity of destruction of benign skin lesions FCHP will request repayment from the provider.

Surgery/Procedure	Medical Necessity Criteria
electrolysis, waxing, or laser hair removal, is cosmetic and not covered, even if the excessive hair is caused by a medical condition.	

### Exclusions

1. Cosmetic surgery, cosmetic treatments, cosmetic procedures, cosmetic medications and cosmetic supplies, including, but not limited to: otoplasty for protruding ears; ear piercing; abdominoplasty; chemical peel (dermal and epidermal); microdermabrasion; and hair removal.
2. Services related to cosmetic surgery, cosmetic treatments, and cosmetic procedures are not covered. This includes but is not limited to: physician charges, hospital charges, charges for anesthesia, drugs, etc.
3. Care of the teeth and supporting structures, including reconstructive, major restorative or cosmetic dental services, such as dental implants (also known as osseointegrated or titanium implants), dentures, crowns, and orthodontics. Care of the teeth and supporting structures is not covered, even when part of a covered medical procedure, such as a cleft lip/palate repair. Similarly, medical or surgical procedures in preparation for a dental procedure are also not covered (for example, a bone graft to prepare for a dental implant). (Some plan members may have a dental rider which provides coverage for certain preventive and minor restorative dental services, such as periodic cleanings and fillings. The services that are covered are listed in the Dental Addendum "*Covered Dental Services Copayments.*")
4. Surgery, treatments, procedures, medications, and supplies related to gender reassignment or the reversal of gender reassignment.
5. Surgery, treatments, procedures, medications, and supplies to prevent snoring.
6. Removal of intact breast implants for suspected autoimmune or connective tissue disease or for breast cancer prevention because these indications are considered experimental/investigational.
7. Removal of an intact breast implant that has shifted. Implant shifting in the absence of refractory infection or Stage IV capsular contracture is not medically necessary.
8. Liposuction, also known as suction lipectomy or suction assisted lipectomy, is the surgical excision of subcutaneous fatty tissue. Liposuction (CPT codes 15876-15879) is not covered. However, liposuction is an integral part of certain covered services, such as the surgical removal of excessive skin (CPT codes 15830-15839), but is not separately reimbursed.
9. Treatments for acne scarring including, but not limited to subcutaneous injections to raise acne scars, chemical exfoliation (CPT 17360), and dermabrasion.
10. The following treatments for active acne are not covered: acne surgery (CPT code 10040), cryotherapy for acne (CPT code 17340), chemical exfoliation for acne (CPT code 17360), and laser and light-based therapies, including but not limited, to blue light therapy, pulsed light, and diode laser treatment.

### Related Policies

Varicose Veins  
 Orthognathic Surgery  
 Surgery for Obstructive Sleep Apnea  
 Temporomandibular Joint Disorder  
 Post-Mastectomy Surgery and Services

## Phototherapy for Skin Conditions

### Products to Which This Policy Applies

- ⊕ FCHP Direct & Select Care
- ⊕ FHLAC Indemnity
- ⊕ Fallon Preferred Care
- ⊕ MassHealth, Commonwealth Care
- ⊕ Non-Group: FCHP Independent Care, Direct Enrollment, & Bill-at-Home
- ⊕ Fallon Senior Plan™

### Committee Review Dates:

Benefit Committee Review Date(s): 08/1996, 10/1996, 02/1999, 07/2003

Technology Assessment Committee Review Date(s): 06/2003, 06/01/2006, 04/08/2008

Technology Assessment Subcommittee review Date(s): 01/2004, 05/23/2006, 01/08/2008, 02/26/2008

#### **IMPORTANT NOTE**

**Not all services are covered for all commercial products or employer groups.** Even though this policy may indicate that a particular service or supply is considered 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 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 and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this Medical Policy & Criteria Statement.