Cosmetic, Reconstructive and Restorative Services Clinical Coverage Criteria

Overview

Cosmetic, Reconstructive, and Restorative procedures encompass as vast array of procedures throughout the entire body. In many instances, the concept of reconstructive overlaps with the concept of medically necessary. A procedure which is restorative for one member's medical condition may be considered cosmetic for another member. Fallon Health typically requires these surgeries to correct a functional impairment, restore an appearance as result of an accidental injury, or correct a congenital defect.

Policy

This Policy applies to the following Fallon Health products:

☒ Commercial

☒ Medicare Advantage

☒ MassHealth ACO

☒ NaviCare

☒ PACE

Fallon Health uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for Medicare Advantage, NaviCare and PACE plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and guidance in the Medicare manuals are the basis for coverage determinations. When there is no NCD, LCD, LCA or manual guidance, Fallon Health Clinical Coverage Criteria are used for coverage determinations.

Fallon Health requires Prior Authorization for Cosmetic, Reconstructive and Restorative Services. When procedures require previous attempts at conservative treatment medical records from the primary care physician and other providers (for example, dermatologist, orthopedic surgeon, physical therapist, etc.) who have diagnosed or treated the symptoms prompting this request are also required.

Fallon Health 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:

- 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
- What the etiology of the defect is (e.g., congenital defect or birth abnormality, accidental injury, prior surgical procedure, or disease).

Fallon Health covers restorative surgery to repair or restore appearance damaged by accidental injury. Only the initial repair is covered. If a procedure is normally done in stages, with healing periods in-between, all stages are covered. 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.

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.

Eyelids
For Medicare Advantage, NaviCare and PACE plan members, Fallon Health follows **National Government Services, Inc. Local Coverage Article for Blepharoplasty (A52837)** for coverage criteria for blepharoplasty related procedures.

Upper blepharoplasty: A surgical procedure to remove redundant (excess) tissue from the upper eyelid(s):

- To correct prosthesis difficulties associated with an ophthalmic socket.
- To repair conditions causing corneal or conjunctival irritation, such as entropion, ectropion, pseudotrichiasis, or chronic dermatitis (caused by redundant eyelid tissue).
- 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.
- To relieve painful symptoms (severe squinting secondary to uncontrollable spasms of the periorbital muscles) of primary essential idiopathic blepharospasm, when other treatments have failed. To repair or restore appearance that was damaged by an accidental injury (only the initial restorative repair is covered).

Blepharoptosis repair: 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. 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.

Upper blepharoplasty and/or blepharoptosis repair may be medically necessary to remove excess upper eyelid tissue and/or repair a drooping eyelid causing a functional visual impairment when all the following criteria are met:

1. Documented visual complaints, such as difficulty reading, walking, or driving.
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 margin taped to demonstrate potential correction by the proposed procedure or procedures:
    a. Visual field obstruction by the eyelid at rest must limit the upper visual filed to within 30 degrees measured from the central fixation point.
    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.

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.

Nose

Excision or surgical planning of rhinophyma: 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.

1. Excision or shaving of rhinophyma may be medically necessary to treat rhinophyma that is causing a nasal obstruction that is impairing respiratory function (obstructing rhinophyma).

Rhinoplasty: 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. Rhinoplasty may be medically necessary 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:

1. Photographic documentation (if there is an external nasal deformity) along with objective documentation that substantiates the severity of symptoms.
2. There are no other identifiable causes, e.g., polyps, allergies, turbinate hypertrophy, septal defect, or chronic lung disease.
3. Documentation that a reasonable trial of appropriate physician supervised conservative treatment has failed.
4. Septoplasty and/or turbinectomy alone would not be expected to resolve the condition.

Additionally, Rhinoplasty may be covered for the below indications:

1. 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 is about 16 years of age. (Primary nasal repair is usually done at the time of the primary cleft lip repair.)
2. To repair or restore appearance that was damaged by an accidental injury (only the initial restorative repair is covered).

Septoplasty: 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. Septoplasty may be medically necessary 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:

1. 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).
2. There are no other identifiable causes, e.g., polyps, allergies, turbinate hypertrophy, or chronic lung disease.
3. Documentation that a reasonable trial of appropriate physician supervised conservative treatment has failed, including the duration and dose of the actual treatments; antibiotics, nasal steroids.

Additionally, Septoplasty may be covered for the below indications:

1. 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.
2. To repair a nasal deformity secondary to cleft lip / palate or other congenital deformity that is causing a physical functional impairment.

Ears
Total external ear reconstruction: Reconstruction that is usually performed in stages. Each stage is spaced several months apart to allow for healing. Total external ear reconstruction does not include reconstruction of the external auditory canal. Total external ear reconstruction may be medically necessary:

To repair a congenital deformity (microtia) of the external ear (auricle) when criterion 1 or 2 and 3 are met:
1. Audiology evaluation and hearing testing document a significant hearing impairment and there is a likelihood that ear reconstruction will improve the hearing impairment.
2. To facilitate the use of eyeglasses or a hearing aid.
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.

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.

Reconstruction of the external auditory canal may be medically necessary:
1. To repair congenital atresia that is causing a significant hearing loss, and there is a likelihood that the procedure will improve the hearing impairment.
2. To repair a deformed (e.g., stenotic) external auditory canal caused by disease or previous surgery when a significant hearing loss is documented.
3. To repair or restore appearance that was damaged by accidental injury (only the initial restorative repair is covered).

Facial (Includes the upper and lower jaw and the chin)
Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (NCD 250.5) for Medicare Advantage, NaviCare and PACE plan members
Dermal injections of FDA- approved dermal fillers (i.e., poly-L-lactic acid dermal injection (Sculptra) or calcium hydroxylapatite dermal injection (Radiesse)) are covered for the treatment of facial lipoatrophy in HIV-positive Medicare Advantage, NaviCare or PACE plan member when:
1. Facial lipoatrophy is caused by antiretroviral treatment, and
2. Facial lipoatrophy contributes significantly to depression in the plan member.

Injection of dermal fillers for any indication other than the treatment of HIV-associated lipodystrophy syndrome is not covered. Dermal fillers that are not approved by the FDA for the treatment of HIV-associated lipodystrophy syndrome are not covered.

Rhytidectomy: A surgical procedure to remove redundant (excess) skin from the facial area. This procedure is commonly known as a facelift. Rhytidectomy may be medically necessary:
1. To restore appearance that was damaged by accidental injury (only the initial restorative repair is covered).
2. 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.

Repair of cleft lip with or without nasal deformity (cheiloplasty): 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.

Primary repair of cleft lip with or without a nasal deformity may be medically necessary:

1. 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.

Secondary repair of cleft lip may be medically necessary:
1. 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.

Palatoplasty for cleft palate: 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 graft (see Maxillary alveolar cleft repair with bone graft below).

Sequelae of cleft lip and / or palate:
- Nasolabial, oromaxillary, and/or oronasal fistula(s)
- Maxillary alveolar ridge cleft

Primary palatoplasty may be medically necessary:
1. 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.

Secondary palatoplasty may be medically necessary:
1. 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.

Maxillary alveolar cleft repair with bone graft: Is a cleft of the dental ridge (gum line) of the upper jaw (maxilla) that commonly occurs in children with facial clefts. Maxillary alveolar cleft ridge repair may be medically necessary:
1. To repair a congenital maxillary alveolar cleft that is causing a physical functional impairment, such as, when the cleft impairs normal dental development.

Repair of nasolabial, oromaxillary, and/or oronasal fistula(s): 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. Fistulas may also be caused by infection, trauma or as a complication of removing a tooth. Repair of nasolabial, oromaxillary, and/or oronasal fistula(s) may be medically necessary:
1. To repair a fistula that is causing a physical functional impairment, such as difficulty eating or drinking or when the fistula impairs speech

Mentoplasty: Refers to plastic surgery procedures for the chin. Mentoplasty may be medically necessary:
1. To repair or restore appearance that was damaged by accidental injury (only the initial restorative repair is covered).
2. 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.
3. In conjunction with a covered orthognathic surgery to correct deformities of the jaw.

Please see Fallon Health's separate policy for Orthognathic Surgery.

Chest
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. Additionally Fallon Health will consider coverage for reconstruction post-Lumpectomy. All other breast procedures must meet the below criteria.

Mammoplasty
There are three general categories of mammoplasty (i.e., plastic surgery performed on the breasts):
- Augmentation mammoplasty: Augmentation mammoplasty is a surgical procedure in which the breasts are augmented or enlarged, usually with implants placed under or over chest muscle. (Note: coverage is limited for this procedure only for post-mastectomy or lumpectomy.)
- Reduction mammoplasty: Reduction mammoplasty is a surgical procedure in which excess breast tissue is excised.
- Breast reconstruction: Breast reconstruction 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.

Medicare does not have a National Coverage Determination (NCD) for breast reduction (reduction mammaplasty). Fallon Health follows National Government Services, Inc. **Local Coverage Determination (LCD) for Reduction Mammaplasty (L35001)** coverage criteria for reduction mammaplasty for Medicare Advantage, NaviCare and PACE plan members. See related **Local Coverage Article for Reduction Mammaplasty (A57759)** for additional information.

Reduction mammoplasty: Reduction mammoplasty may be medically necessary to relieve a physical functional impairment caused by hypertrophic breasts when all of the following criteria are met:
Medical records from the primary care physician and other providers (for example, dermatologist, orthopedic surgeon, physical therapist, etc.) who have diagnosed or treated the symptoms prompting this request are also required.
1. The patient is 16 years of age or older and has reached physical maturity.
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.
3. The patient has significant symptoms that have interfered with activities of daily living, despite physician supervised conservative management, for at least six months, including at least one of the following:
    a. Back and/or shoulder pain unrelieved by physician supervised conservative measures including analgesia (e.g., NSAIDs, compresses, etc.), supportive garments, physical therapy, and correction of obesity (defined as BMI > 35).
    b. Significant, symptomatic arthritic changes (signs and symptoms of ulnar paresthesias, cervicalgia, torticollis or kyphosis) in the cervical or upper thoracic spine.
    c. Intertriginous maceration or infection of the inframammary skin, refractory to dermatologic measures.
    d. Shoulder grooving with skin irritation (areas of excoriation and breakdown) by appropriate supporting garment.

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 Fallon Health medical criteria based on body surface area that address the anticipated amount of breast tissue to be excised:

Minimum Weight of Breast Tissue Removed, per Breast , as function of Body Surface Area – Schnur Sliding Scale	
Body Surface Area	Minimum weight of tissue to be removed per breast (grams)
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978
2.30 or greater	>/= 1000

Breast reconstruction may be medically necessary:
1. To repair or restore appearance of a breast that was damaged by accidental injury (only the initial restorative repair is covered).
2. To repair or restore appearance of one or both breasts following a covered prophylactic mastectomy.

Removal of breast implants: Implants do not last a lifetime and will likely need to be removed either because of rupture, capsular contracture, or other complications. There are two main types of breast implants Saline-filled breast implants and Silicone gel-filled breast implants. Both types of breast implants have a silicone rubber protective shell (capsule). 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). Removal of either a silicone gel-filled breast implant or a saline-filled breast implant may be medically necessary:
1. To facilitate the treatment of breast cancer.
2. For the treatment of persistent or recurrent local or systemic infection, secondary to a breast implant, that is refractory to medical management including antibiotics.
3. For the treatment of Baker Grade IV Capsular Contracture that is causing pain, persistent infection refractory to medical management, or is interfering with preventive breast cancer screening.
   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

4. 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.

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.

Even when removal of breast implants meets medical necessity criteria, reinsertion of replacement breast implants is considered cosmetic and is not covered.

Mastectomy for gynecomastia: 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. 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 treatment other than removal of the precipitating cause. Psuedogynecomastia 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:

1. 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
2. The patient has had a consult with an endocrinologist to identify and treat or correct any underlying causes, AND
3. Despite treatment or correction of any underlying causes, gynecomastia and signs/symptoms have persisted for greater than 12 months with no evidence of reversal; AND
4. 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
5. Preoperative photographs are provided.

Mastopexy: Also known as a breast lift surgery refers to a surgical procedure designed to lessen the degree of breast ptosis (sagging). Mastopexy is not a covered benefit (except following a mastectomy; refer to Post-Mastectomy Surgery and Services policy for additional information).

Prophylactic mastectomy: The preventive surgical removal of one or both breasts to prevent or reduce the risk of breast cancer. 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. Prophylactic mastectomy may be medically necessary:

1. To prevent or reduce the risk of breast cancer in a female patient with a known BRCA1 or BRCA2 mutation confirmed by genetic testing.
2. To prevent or reduce the risk of breast cancer in a female patient who has a first or second-degree relative with a known BRCA1 or BRCA2 mutation confirmed by genetic testing.
3. To prevent or reduce the risk of recurrent breast cancer in a male or female patient with a personal history of breast cancer.

Congenital chest wall deformities: Deformities that 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 90% of all congenital chest wall procedures.

1. Surgical repair of pectus excavatum may be medically necessary when the Haller Index (transverse chest to narrowest anterioposterior diameter) is 3.25 or higher.

2. Surgical repair of pectus carinatum may be medically necessary when a rigid or restrictive chest wall results in less than optimal respiration, such as incomplete expiration, or exertional dyspnea. 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).
3. Surgical repair of Poland syndrome may be considered medically necessary 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.

Surgical repair of inverted nipple: An 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. Surgical repair of inverted nipple may be medically necessary:
1. 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.

Abdomen
Panniculectomy: The surgical excision of redundant (excess) hanging abdominal skin and fat (panniculus) but does not include muscle plication or neoumbilicoplasty as in an abdominoplasty. 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. Panniculectomy may be medically necessary:

Medical records from the primary care physician and other providers (for example, dermatologist, orthopedic surgeon, physical therapist, etc.) who have diagnosed or treated the symptoms prompting this request are also required.
1. The panniculus hangs below the level of the pubis (photographic documentation is required), AND
2. The panniculus is the result of weight loss, AND
3. 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
4. It is documented in the patient's medical record that the panniculus directly impairs physical function, i.e., the panniculus: Interferes with ambulation, urination or other activities of daily living, or
5. 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.

Panniculectomy and abdominoplasty are often performed together to achieve the best cosmetic result. (Abdominoplasty is an add-on procedure that cannot be billed alone). Abdominoplasty is not a covered benefit.

Diastasis recti abdominis repair: 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. Diastasis recti abdominis repair may be medically necessary:

1. 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.

Skin
Tattooing: The introduction of insoluble pigments to correct color defects of the skin.
Tattooing may be medically necessary:
1. To give the nipple-areola complex a more natural appearance following breast reconstruction surgery.
2. 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).

Tattooing is not separately reimbursable in conjunction with radiation therapy.

Tattooing is considered cosmetic (i.e., not medically necessary) for the treatment of vitiligo because it does not treat the underlying condition or result in improved protection against skin cancer.

Tattoo removal: 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. Removal of a decorative tattoo is not covered. Tattoo removal may be medically necessary:
1. To remove a positional tattoo placed to facilitate radiation therapy.

Scar revision: 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.
Several techniques can minimize a scar however no scar can ever be completely removed. Fallon Health covers the following scar revision techniques:
- Tissue transfer, i.e., flaps and grafts
- Scar reexcision
- Scar rearrangement (i.e., Z-plasty, W-plasty)
- Abrasion or dermabrasion
- Pulsed dye laser
- Intralesional corticosteroid injections

Scar revision may be medically necessary:
1. 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 Fallon Health), or
2. 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
3. When the scar has a history of intermittent breakdown.

Excision of redundant (excess) skin and subcutaneous tissue of the thighs, hips, buttocks, arms, or other anatomical areas - (See Panniculectomy for excision of redundant skin and subcutaneous tissue of the abdomen) 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. Excision of redundant (excess) skin and subcutaneous tissue of the thighs, hips, buttocks, arms, or other anatomical areas, may be medically

necessary:

1. 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
2. It is documented in the patient's medical record that the redundant skin directly causes a physical functional impairment; i.e., the redundant skin:
    a. Interferes with mobility, urination, or other activities of daily living, or
    b. 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
3. The redundant skin is documented in photographs.

Subcutaneous injection of filling material: 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. Injection of filling materials is not covered for the treatment of acne or chicken pox scars, facial wrinkles or other cosmetic purposes. Subcutaneous injection of filling material may be medically necessary

1. 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 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.)

Abrasion: Is typically 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. Abrasion may be medically necessary:

1. To improve the appearance of a small scar that is the result of an accidental injury (restorative).
2. To remove a positional tattoo placed to facilitate radiation therapy

Dermabrasion: Is typically 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, CO2 or YAG laser, or a curette. 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. Dermabrasion for removal of acne, or acne or chicken pox scars is considered cosmetic and not medically necessary.

Dermabrasion may be medically necessary:

1. To improve the appearance of a large scar or a large area of scarring that is the result of an accidental injury (restorative).
2. To remove a positional tattoo placed to facilitate radiation therapy.

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).

Please see Fallon Health's separate policy for Varicose Vein Treatment for detailed coverage of these procedures.

Hair

Hair transplant: 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). 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. Hair transplant may be medically necessary:

1. To improve the appearance of a scar in the scalp that is the result of an accidental injury (restorative).

Exclusions

- 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.
- 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.
- 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.”)
- Surgery, treatments, procedures, medications, and supplies to prevent snoring.
- Removal of intact breast implants for suspected autoimmune or connective tissue disease or for breast cancer prevention because these indications are considered experimental/investigational.
- 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.
- 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.
- Treatments for acne scarring including, but not limited to subcutaneous injections to raise acne scars, chemical exfoliation, and dermabrasion.
- The following treatments for active acne are not covered: acne surgery, 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.
- Otoplasty to correct protruding ears, with or without size reduction (CPT code 69300).
- Ear piercing is cosmetic surgery and not medically necessary.
- Chemical peels (dermal and epidermal) are not covered. 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).
- Hair removal, by any method, temporary or permanent, including, but not limited to, electrolysis, waxing, or laser hair removal, is cosmetic and not covered, even if the excessive hair is caused by a medical condition.

Policy history

Origination date:	06/2000
Approval(s):	Benefit Review Committee: 08/1996, 10/1996, 02/1999, 07/2003 Technology Assessment Subcommittee: 06/2003, 06/01/2006, 04/08/2008 Technology Assessment Committee: 01/2004, 05/23/2006, 01/08/2008, 02/26/2008, 03/26/2013, 02/25/2015 (updated template, coverage for post-lumpectomy breast reconstruction, removed procedures that do not require Prior Authorization) 02/24/2016 (annual review no changes), 04/26/2017 (added clarification that medical records are required directly from providers who treat conservatively prior to requests for procedures), 03/28/2018 (annual review, no changes), 03/27/2019 (annual review, no updates) *06/15/2021 (Added clarifying language related to Medicare Advantage, NaviCare and PACE under policy section).*

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates 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. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.