Cosmetic Procedures

Policy Number:	**M020808388**
Effective Date:	**8/8/2002**
Sponsoring Department:	**Health Care Services**
Impacted Department(s):	**Health Care Services**

Type of Policy: ☒ Internal ☒ External

Data Classification: ☐Confidential ☐Restricted ☒Public

Applies to (Line of Business):

☐ Corporate (All)
☒ State Products, if yes which plan(s): ☒MediSource; ☒MediSource Connect; ☒Child Health Plus; ☒Essential Plan
☒ Medicare, if yes, which plan(s): ☒MAPD; ☐PDP; ☒ISNP; ☒CSNP
☒ Commercial, if yes, which type: ☒Large Group; ☒Small Group; ☒Individual
☒ Self-Funded Services *(Refer to specific Summary Plan Descriptions (SPDs) to determine any pre-authorization or pre-certification requirements and coverage limitations. In the event of any conflict between this policy and the SPD of a Self-Funded Plan, the SPD shall supersede the policy.)*

Excluded Products within the Selected Lines of Business (LOB)

N/A

Applicable to Vendors? Yes ☐ No☒

Purpose and Applicability:

To set forth the guidelines and/or medical necessity criteria for a cosmetic or plastic surgery procedure.

Policy:

Commercial and Self-Funded:
Generally **Cosmetic procedures** are not considered medically necessary and are a covered benefit only when the member's contract contains a cosmetic rider.

However, requests for procedures may be authorized if it is determined that there is a functional deficit and medically necessary. Functional deficit causes deviation from the normal function of a tissue or organ which results in a significantly limited, impaired, or delayed capacity to perform physical activities of daily living. These requests are reviewed by the Medical Director on a case-by-case basis.

For procedures generally considered cosmetic, but requested related to gender dysphoria treatment, please see Gender Dysphoria Treatment policy.

Common Cosmetic Procedures That May Be Authorized
Note: Please visit the Independent Health Medical Services Requiring Authorization web site (Medical Services Requiring Authorization [login required]) to determine if additional criteria is utilized for a specific cosmetic procedure.

Examples of procedures commonly used for cosmetic purposes that may be authorized based on medical necessity as established by the presence of a functional deficit include, but are not limited to, the following:

Abdominoplasty, also known as "tummy tuck" or belt lipectomy, is considered a cosmetic procedure and is not medically necessary. It is a covered benefit only when the member-s contract contains the cosmetic rider. Abdominoplasty may be covered in relation to ventral hernia repair on a case-by-case basis.

Acne surgery (the treatment of both non-inflammatory and some inflammatory acne lesions using instruments including extraction of non-inflamed lesions, triamcinolone acetate injections of some inflamed lesions, and extraction of milia).

Alopecia areata treatment may include intralesional injections of corticosteroids or topical corticosteroids. Extensive alopecia areata, including alopecia totalis, may include short treatment courses of systemic glucocorticoid therapy which may induce hair regrowth, and as an attempt to halt rapidly progressing, widespread disease.

Augmentation Mammoplasty (also known as breast augmentation): In conjunction with a cancer diagnosis or gender dysphoria treatment.

Breast Asymmetry Correction: In conjunction with a cancer diagnosis or congenital absence of breast (e.g., Poland's Syndrome).

Breast Implant Removal: In conjunction with a cancer diagnosis or a ruptured prosthesis causing a functional deficit.

Chemical Exfoliation/Chemical Peel: For actinic keratoses and other pre-malignant skin lesions medically necessary when members have 15 or more lesions, such that it becomes impractical to treat

each lesion individually, and they have failed to adequately respond to treatment with topical 5-FU or imiquimod, unless contraindicated.

Collagen Implants: Fat or silicone injections to correct a functional deficit resulting from a medical condition.

Dental Implants: Please refer to the Dental Care Provided Under the Medical Benefit policy.

Dermabrasion using the conventional method of controlled surgical scraping (dermaplaning) or carbon dioxide (CO2) laser for removal of superficial basal cell carcinomas and pre-cancerous actinic keratoses medically necessary when both of the following criteria are met:

- Conventional methods of removal such as cryotherapy, curettage, and excision, are impractical due to the number and distribution of the lesions; and
- The member has failed a trial of 5-fluorouracil (5-FU) (Efudex) or imiquimod (Aldara), unless contraindicated.

Destruction of Cutaneous Vascular Proliferative Lesions treatment, including laser, of congenital port wine stains and hemangiomas when functional deficit is documented is considered medically appropriate**.**

Earlobe Repair due to trauma (accident, dog bite, etc.).

Genioplasty due to jaw and cranio-facial deformities which may cause significant functional impairment.

- **Genioplasty;** Augmentation
- **Genioplasty;** Sliding osteotomy, single piece
- **Genioplasty;** Sliding osteotomies
- **Genioplasty;** Sliding, augmentation

Gynecomastia Correction: Gynecomastia is defined as the presence of breast subareolar tissue of at least 2 cm in diameter in the supine male patient and requires an appropriate evaluation by an endocrinologist to rule out reversible cause of gynecomastia. Glandular breast tissue is the primary cause of gynecomastia as opposed to fatty deposits and is documented on physical exam and/or mammography.

Labiaplasty: Labiaplasty refers to surgical alteration of the labia minora or majora, but typically reduction of the labia minora is performed. The overall goals of labiaplasty include the reduction of the hypertrophic labia minora, maintenance of the neurovascular supply, preservation of the vaginal orifice (introitus), optimization of the color and texture of the labial edge, and minimal invasiveness. Non-cosmetic procedures may be performed to alleviate injury, trauma, or chronic irritation after conservative measures have failed.

Liposuction (lipectomy): Liposuction may be performed for medically necessary treatment of lipomas, gynecomastia, pseudogynecomastia, lipodystrophy, and axillary hyperhidrosis. Weight loss is NOT considered an indication for liposuction.

Mastopexy (breast lift) in post-mastectomy or partial mastectomy (e.g., lumpectomy, segmentectomy, quadrantectomy) patients is considered medically appropriate per NY State Law.

Otoplasty (revision or reconstruction of the ear)

Panniculectomy may be considered medically appropriate when there is documentation of a significant functional deficit according to the following criteria:

- Office notes and photos from the appropriate providers must document BOTH:
  - Panniculus hangs below the level of the pubis; and
  - Pannus causes a persistent or frequently occurring cellulitis, abscess or skin ulceration that has not responded to a trial of at least three months of medical therapy. Treatment should include topical antifungals, topical and/or systemic corticosteroids, and /or local or systemic antibiotics.

- If panniculectomy is requested following significant weight loss, there should be evidence that the individual has maintained stable weight for at least six months prior.

- If the weight loss is the result of bariatric surgery, panniculectomy should not be performed until at least 18 months after bariatric surgery and only when weight has been stable for at least the most recent six months.

- Panniculectomy is not considered medically necessary for the following:
  - Solely for the correction of poorly fitting clothes, problems with hygiene or difficulty, as no functional deficit exists; or
  - The treatment of superficial inflammation or infection controlled with topical medicines; or
  - Solely for the correction of low back pain since the cause of low back pain in most individuals is multi-factorial and the primary cause may not be the abdominal panniculus.

Rhinoplasty: Rhinoplasty will be covered only in cases where a functional nasal deformity is established. The internal nasal deformity must be of a degree which could not be corrected by a routine endonasal septoplasty approach to address the internal nasal deformity. Pictures are required consisting of an anterior view, lateral view and submental view. Rhinoplasty must meet the following criteria:

- Nasal airway obstruction or difficulty breathing through nose; or
- Rhinolalia clausa or
- Epistaxis; or
- An external nasal deformity, which contributes to the above condition as evidenced by:
  - nose off midline; or
  - narrow nose; or
  - severely bent nose; or
  - valvular stenosis.

Rhytidectomy (Facelift) for correction of a documented functional deficit from facial nerve palsy.

Scar Revision treatment via surgery or intralesional steroid injection is considered medically appropriate when scars cause a functional deficit**.**

Sclerotherapy: See Independent Health Varicose Veins Policy

Skin Tag Excisions when skin tags are located in areas subject to repeated irritation and bleeding**.**

Telangiectasis treatment of rosacea when there is a documented functional deficit, using procedures such as photoablation, laser treatment, sclerosing injections or ultraviolet light therapy.

Testicular Implant: In conjunction with a cancer diagnosis and/or traumatic injury with removal of testicles.

Medicare Advantage:
Utilizing the criteria above, cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member.

MediSource, MediSource Connect, and Essential Plan:
Utilizing the criteria above, payment will not be made for medical care and services which are medically unnecessary and were for cosmetic purposes and are provided only because of the enrollee's personal preference.

Covered when deemed medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection, or other diseases of the involved body part.

For procedures generally considered cosmetic, but requested related to gender dysphoria treatment, please see Gender Dysphoria Treatment policy.

Child Health Plus:
Utilizing the criteria above, covered when deemed medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection, or other diseases of the involved body part or when required to correct a functional deficit resulting from a congenital disease or anomaly.

Background:

The coverage eligibility of medical and surgical therapies for cosmetic purposes is often based on a determination of whether treatment is considered medically necessary, reconstructive, or cosmetic in nature.

An evaluation of the peer-reviewed scientific literature, including but not limited to subscription materials, has provided Independent Health the basis for its medical necessity coverage outlined above.

Pre-Authorization Required? Yes ☒ No☐

Note: Skin tag removal is exempt from the pre-authorization requirement and may be subject to retrospective review.

Note: Pre-authorization for select gender reassignment procedures for MediSource, MediSource Connect, and Essential Plan is not required. Please review the Gender Dysphoria Treatment policy, Policy No. M20151112001.

Definitions

Alopecia areata is a chronic, relapsing, immune-mediated inflammatory disorder affecting hair follicles resulting in nonscarring hair loss.

Breast Augmentation means breast enlargement or breast enhancement by surgery.

Cosmetic surgery or services means procedures performed in order to improve the member's appearance and self-esteem.

Functional Deficit (or impairment) is a deficit that causes deviation from the normal function of a tissue or organ which results in a significantly limited, impaired, or delayed capacity to perform physical activities of daily living.

Genioplasty is an operation performed to reshape the chin.

Liposuction means the removal of localized deposits of adipose tissues that do not respond to diet and exercise.

Medical Necessity has the meaning set forth in the member's or participant's coverage document.

Panniculectomy is a surgical procedure to remove a large flap or *apron* (panniculus) of redundant skin and subcutaneous fat that hangs down from the abdomen covering the pubis and groin.

Reconstructive surgery or procedures are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease.

Rhinolalia clausa is abnormal speech secondary to nasal obstruction.

Rhinoplasty is a surgical procedure for correcting and reconstructing the form, restoring the functions, and/or aesthetically enhancing the nose.

Sclerotherapy means the treatment involving the injection of a sclerosing solution into vessels or tissues.

Septoplasty is a surgical procedure performed to repair defects or deformities of the nasal septum.

References

Related Policies, Processes and Other Documents
Dental Care Provided Under the Medical Benefit, Policy No. M010712307
Gender Dysphoria Treatment, Policy No. M20151112001
Varicose Veins, Policy No. M050801572

Non-Regulatory references
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Regulatory References
Centers for Medicare and Medicaid Services (CMS)[web site]; Medicare Benefit Policy Manual Chapter 16 - General Exclusions from Coverage; 120 Cosmetic Surgery. (Rev. 198, 11-06-14). Available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf Accessed January 22, 2024.

New York State Department of Health eMedny [web site]. New York State Medicaid Program Information for All Providers. Version 2022-2 Available at: https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Policy.pdf Accessed January 22, 2024.

This policy contains medical necessity criteria that apply for this service. Please note that payment for covered services is subject to eligibility criteria, contract exclusions and the limitations noted in the member's contract at the time the services are rendered.

Version Control

Signature / Approval on File? Yes ☒ No☐

Revision Date	Owner	Notes
3/1/2024	Health Care Services	Reviewed
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1/1/2016	Medical Management	Revised
6/1/2015	Medical Management	Revised
5/1/2014	Medical Management	Revised
1/1/2014	Medical Management	Revised
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