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:

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 below.

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.

Medicare Advantage:
Utilizing the criteria below, 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 below, 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.

Child Health Plus:
Utilizing the criteria below, 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.

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~~ are utilized for a specific cosmetic procedure. For procedures generally considered cosmetic, but requested related to gender dysphoria treatment, please see Gender Dysphoria Treatment policy. For Dental Implants: Please refer to the Dental Care Provided Under the Medical Benefit policy. Sclerotherapy: See Independent Health Varicose Veins Policy.

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 those listed in the clinical indications below.

Clinical Indications:

Cosmetic procedures may be authorized for **1 or more** of the following:

- Member's contract contains a cosmetic rider
- A functional 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 (These requests are reviewed by the Medical Director on a case-by-case basis) and **1 or more of the following:**
    - Abdominoplasty, (Also known as "tummy tuck" or belt lipectomy) for **1 or more** of the following:
        - In relation to ventral hernia repair
    - 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 for **1 or more** of the following:
        - In conjunction with a cancer diagnosis
        - In conjunction with gender dysphoria treatment [see Gender Reassignment Treatment (Formerly Gender Dysphoria Treatment) policy]
    - Breast Asymmetry Correction for **1 or more** of the following:
        - In conjunction with a cancer diagnosis
        - Congenital absence of breast (e.g., Poland's Syndrome)
    - Breast Implant Removal for **1 or more** of the following:
        - In conjunction with a cancer diagnosis
        - Ruptured prosthesis causing a functional deficit
    - Chemical Exfoliation/Chemical Peel for **1 or more** of the following:
        - Actinic keratoses and/or other pre-malignant skin lesions and **ALL** of the following:
            - 15 or more lesions present (Such that it becomes impractical to treat each lesion individually)
            - Failure to adequately respond to treatment with topical 5-FU or imiquimod, unless contraindicated
    - Collagen Implants (Fat or silicone injections) for **1 or more** of the following:
        - To correct a functional deficit resulting from a medical condition
    - Dermabrasion [Using the conventional method of controlled surgical scraping (dermaplaning) or carbon dioxide (CO_2) laser] for **1 or more** of the following:
        - Removal of superficial basal cell carcinomas and pre-cancerous actinic keratoses and **ALL** of the following:
            - Conventional methods of removal such as cryotherapy, curettage, and excision, are impractical due to the number and distribution of the lesions
            - 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)
- Earlobe Repair for **1 or more** of the following:
  - Trauma (accident, dog bite, etc.)
- Genioplasty for **1 or more** of the following:
  - Jaw and/or cranio-facial deformities
- Gynecomastia Correction and **ALL** of the following:
  - Presence of breast subareolar tissue of at least 2 cm in diameter in the supine male patient
  - 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 for **1 or more** of the following:
  - To alleviate injury, trauma, or chronic irritation after conservative measures have failed
- Liposuction (Lipectomy) for **1 or more** of the following:
  - Lipomas
  - Gynecomastia
  - Pseudogynecomastia
  - Lipodystrophy
  - Axillary hyperhidrosis
- Mastopexy (Breast lift) for **1 or more** of the following:
  - Post-mastectomy or partial mastectomy (e.g., lumpectomy, segmentectomy, quadrantectomy) patients (Considered medically appropriate per NY State Law)
- Otoplasty (Revision or reconstruction of the ear)
- Panniculectomy* for **1 or more** of the following:
  - If Panniculectomy is requested following significant weight loss **ALL** of the following:
    - Office notes and photos from the appropriate providers must document **ALL** of the following:
      - Panniculus hangs below the level of the pubis
      - 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)
    - Evidence that the individual has maintained stable weight for at least six months prior
  - If Panniculectomy is requested following weight loss, and weight loss is the result of bariatric surgery **ALL** of the following:
    - Office notes and photos from the appropriate providers must document **ALL** of the following:
      - Panniculus hangs below the level of the pubis
      - 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)
- 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

- Rhinoplasty for a functional nasal deformity and **ALL** of the following:
  - 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
  - Requests for Rhinoplasty must meet **1 or more** of the following:
    - Nasal airway obstruction or difficulty breathing through nose
    - Rhinolalia clausa
    - Epistaxis
    - An external nasal deformity, which contributes to the above condition as evidenced by **1 or more** of the following:
      - Nose off midline
      - Narrow nose
      - Severely bent nose
      - Valvular stenosis
- Rhytidectomy (Facelift) for **1 or more** of the following:
  - Correction of a documented functional deficit from facial nerve palsy
- Scar Revision (Treatment via surgery or intralesional steroid injection)
- Skin Tag Excisions for **1 or more** of the following:
  - 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 for **1 or more** of the following:
  - In conjunction with a cancer diagnosis
  - Traumatic injury with removal of testicles

Requests are **NOT COVERED** for **ANY** of the following:
- Procedures that are cosmetic and not medically necessary

*Note: 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.

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.

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.

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
8/1/2025	Health Care Services	Revised- Formatting only
3/1/2025	Health Care Services	Reviewed – no revisions
3/1/2024	Health Care Services	Reviewed
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11/1/2017	Medical Management	Revised
12/1/2016	Medical Management	Revised
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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