



Cosmetic Surgery & Procedures Coverage Guidelines

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Purpose:

To provide cosmetic guidelines for the Medical Department staff to reference when making benefit determinations.

Compliance Status

- Centers for Medicare & Medicaid Services (CMS)

Additional Information

- This policy statement supplements plan coverage language by identifying procedures that are considered not medically necessary.
- While this policy addresses many common procedures, it does not address all procedures that might be considered to be cosmetic surgery and excluded from coverage.

Coverage Guidelines

The following procedures may be considered medically necessary if criteria and/or guidelines are met after documentation, including photographs are reviewed and procedure is not specifically excluded as a covered benefit:

- Blepharoplasty;
- Collagen implant (e.g., Zyderm): When used as a treatment for urinary incontinence;
- Rhinoplasty: Repair of a traumatic injury;
- Earlobe repair: Repair (e.g., tear) of a traumatic injury;
- Lipomas: Which are tender and inhibit the member's ability to perform daily activities due to the lipomas' location on body parts;
- Port wine stains and other hemangiomas: When lesions are located on the face and neck and cause symptoms and functional impairment;
- Scar revision: Repair of scars that result from surgery if they cause symptoms and functional impairment;
- Skin tag removal: When located in an area of friction with documentation of repeated irritation and bleeding;
- Tattoo: Only in conjunction with reconstructive breast surgery post-mastectomy.



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Exclusion Criteria

The following procedures are considered cosmetic and not covered. These include, but are not limited to:

- Excision, excessive skin, thigh, leg, hip, buttock, arm, forearm or hand, submental fat pad, and any other areas
- Salabrasion
- Grafts, fat
- Chemical peels (chemical exfoliation)
- Dermabrasion
- Electrolysis or laser hair removal
- Hair Restoration
- Abdominoplasty / Panniculectomy
- Suction-assisted lipectomy (Liposuction)
- Ultrasound-assisted Liposuction
- Correction of diastasis recti abdominis
- Removal of spider angiomas
- Reduction of labia minora
- Gynecomastia surgery, Bilateral
- Breast augmentation (breast implants and pectoral implants) (see member contract for specific limitations)
- Breast Lift (Mastopexy)
- Otoplasty (Correction of large or protruding ears when the surgery will not improve hearing)
- Rhytidectomy (including meloplasty, face lift)
- Poly-L-lactic acid injection (e.g., Sculptra)
- Chin implant (genioplasty, mentoplasty)
- Cheek implant (malar implants)

References:

1. Medicare Benefit Policy Manual Pub. 100-2 Ch.16 (120) Cosmetic Surgery – 2007.
2. American Academy of Cosmetic Surgery; Guidelines for Liposuction surgery 2006; Guidelines for Breast Augmentation surgery 2003; Guidelines for Sclerotherapy 2003.
3. American Society of Plastic Surgeons; On-line Publication: Physician's Guide to Cosmetic surgery – 2007.
4. Lasers for facial rejuvenation: A review. Int J Dermatol. 2003;42(6):480-487.
5. State of Minnesota, Health Technology Advisory Committee (HTAC). Tumescant liposuction. St. Paul, MN: HTAC; 2002.



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6. Outcomes of abdominoplasty. Bazian Ltd., eds. London, UK: Wessex Institute for Health Research and Development, University of Southampton; 2003.
7. Treatment of facial lipoatrophy with intradermal injections of poly lactic acid in HIV-infected patients. *J Acquir Immune Defic Syndr.* 2005;38(4):393-398.
8. NewFill for skin augmentation: A new filler or failure? *Dermatol Surg.* 2005;31(7 Pt 1):772-776; discussion 776.

Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.