Quartz

Cosmetic and Reconstructive Surgery

Last Revision/Review Date: July 15, 2020 **P&P # C.5.14**

Policy

The Medical Management Department reviews referral requests for authorization of Cosmetic and Reconstructive surgery.

This Medical Policy does not constitute medical advice. When deciding coverage, the enrollee's specific plan document must be referenced. The terms of an enrollee's plan document (Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ from this Medical Policy. In the event of a conflict, the enrollee's specific benefit plan document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements, and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. Quartz reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

Procedure

A. Documentation Required:

In order to facilitate the authorization process referral requests must include the following:

a. Physician detailed physical exam and patient medical history;
b. Physical or physiological cause of functional deficit;
c. Appropriate clinical studies/test/interventions to confirm the degree of the impairment;
d. Photographs or descriptive measurement (if applicable to request) of the deformity/anomaly;
e. Treating physician's plan of care (proposed procedures), which must include the expected outcomes of functional improvement as a result of the treatment.

B. General Criteria for Medical Necessity:

Cosmetic and reconstructive surgical procedures are medically necessary if the following criteria are met:

1. The requested procedure has proven efficacy; and is deemed to significantly improve or restore the patient's physiological or physical function; and results in **ONE** of the following:
   a. Restores a bodily function; **OR**
   b. Corrects a physical functional impairment; **OR**
   c. Remedies ongoing or recurrent medical complications which have not been responsive to standard conservative treatment measures for the condition.

NOTE: Removal of benign skin lesions does not require a prior authorization.

C. Medical Necessity Criteria for Specific Conditions:

1. Keloid Removal or Revision

a. Treatment of a keloid is considered medically necessary when there is documented evidence of significant physical or functional impairment related to the keloid and is not specifically excluded in the member's certificate of coverage.

2. Scar Revision

a. Scar revision is considered medically necessary when there is documented evidence of significant physical or functional impairment related to the scar and the treatment can be reasonably expected to improve the physical functional impairment.

D. Indications Considered Experimental, Investigational, or not Medical Necessity because they are considered cosmetic: (*Not all inclusive*)

1. **Eye Procedures: (Cosmetic)**
   a. Epikeratoplasty;
   b. Keratomileusis- refractive eye surgery;
   c. Keratophakia- refractive eye surgery;
   d. Lateral canthopexy;
   e. Medial canthopexy.

2. **Ear Procedures: (Cosmetic)**
   a. Ear Piercing;
   b. Otoplasty;
   c. Total External Ear Reconstruction;
   d. Ear lobe repair of chronic distortion related to ear piercing;
   e. Reconstruction of the ear related to complications from ear piercing.

3. **Facial Procedures: (Cosmetic)**
   a. Forehead reduction;
   b. Malar augmentation
   c. Masseter reduction;
   d. Rhytidectomy;
   e. Genioplasty.

4. **Abdominal Procedures: (Cosmetic)**
   a. Abdominoplasty;
   b. Diastasis recti repair.

5. **Skin Procedures: (Cosmetic)**
   a. Dermabrasion;
   b. Chemical Peel (dermal and epidermal);
   c. Microdermabrasion and chemical peels for photo-aged skin, wrinkles or superficial irregular skin surfaces;
   d. Treatments for acne and acne scarring including, but not limited to dermal fillers to raise acne scar, dermabrasion, acne surgery, cryotherapy for acne, laser resurfacing for facial acne scars or treatment of pain or discomfort from acne;
   e. Removal of a decorative tattoo;
   f. Cosmetic tattooing for treatment of vitiligo;
   g. Removal of skin tags without symptoms of functional impairment or when excluded in the member's certificate of coverage;
   h. Injection (subcutaneous or otherwise) of dermal filling materials for the treatment of acne or chicken pox scars, facial wrinkles or other cosmetic; purposes;

i. Liposuction, also known as suction lipectomy or suction assisted lipectomy (**Exception**: approve liposuction when its used as part of mandated breast reconstruction post mastectomy);
j. Hair removal by any method, temporary or permanent, including, but not limited to, electrolysis, waxing, or laser;
k. Rhytidectomy;
l. Removal of breast tissue in the male for gynecomastia;
m. Buttock lifts, thigh lifts, breast lifts and/or arm lift brachioplasty;
n. Removal of redundant skin after bariatric surgery or weight loss;
o. Permanent cosmetics;
p. Reconstruction procedures related to complications from body piercing;
q. Panniculectomy.

6. Hair Transplants: (Cosmetic)

a. To correct male pattern baldness, age-related hair thinning, baldness (alopecia) due to disease, previous therapy, or congenital scalp disorders.

7. Breast Procedures: (Cosmetic)

a. After breast reconstruction post mastectomy has been successfully completed including documentation of symmetry, additional modification or revisions are not medically necessary.
b. Removal or replacement of breast implant(s) previously included in covered breast reconstruction procedure(s) is not medically necessary except when there is a mechanical complication such as implant rupture or federal recall of that specific implant.

REFERENCES:

Forward Health Restorative Plastic Surgery and Procedures; Topic #13817. Available at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=50&s=2&c=10&nt=Restorative+Plastic+Surgery+and+Procedures Accessed February 24, 2020.

Hayes, Inc. Health Technology Assessment. Panniculectomy for treatment of symptomatic panniculi. Publication date: May 19, 2016. Annual review Jun 2019. Accessed February 24, 2020.

Hayes, Inc. Health Technology Assessment. Sex Reassignment Surgery for the Treatment of Gender Dysphoria. Publication date: Aug 2018. Annual Review Aug 2019. Accessed February 24, 2020.

Jordan R. Cummins CCL, Buris A, Seukeran DDC. Laser resurfacing for facial acne scars. Cochrane Database of Systemic Reviews 2001, Issue 1. Art. No.: CD001866. DOI: 10.1002/14651858.CD001866.