



## Cosmetic and Reconstructive Surgery

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P&P # C.5.14

### Policy

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.

### 3. Breast Surgery

- a. Breast surgery for the purpose of creating symmetrical breasts, including removal or replacement of breast implants, is medically necessary, when post mastectomy or partial mastectomy.
- b. Removal or replacement of breast implant(s) previously included in covered breast reconstruction procedure(s) is considered medically necessary if **ONE** of the following:
  - i. mechanical complication such as implant rupture or extrusion, **OR**
  - ii. symptomatic capsular contraction (i.e. Baker Class 3 or 4), **OR**
  - iii. infectious complication, **OR**
  - iv. federal recall of that specific implant.

### D. Indications Considered 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;

**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. Additional modifications or revisions after breast reconstruction post mastectomy has been successfully completed including documentation of symmetry

**REFERENCES:**

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