Cosmetic, Reconstructive and Restorative Services Clinical Coverage Criteria

Overview

Cosmetic, Reconstructive, and Restorative procedures encompass as vast array of procedures throughout the entire body. In many instances, the concept of reconstructive overlaps with the concept of medically necessary. A procedure which is restorative for one member's medical condition may be considered cosmetic for another member. Fallon Health typically requires these surgeries to correct a functional impairment, restore an appearance as result of an accidental injury, or correct a congenital defect.

Policy

This Policy applies to the following Fallon Health products:

☒ Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO
☒ PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
☒ Community Care

Prior authorization is required for Cosmetic, Reconstructive and Restorative Services. When procedures require previous attempts at conservative treatment medical records from the primary care physician and other providers (for example, dermatologist, orthopedic surgeon, physical therapist, etc.) who have diagnosed or treated the symptoms prompting this request are also required.

Related policies:
Gender Affirming Surgery
Orthognathic Surgery
Post-Mastectomy Surgery and Services
Varicose Veins of the Lower Extremities

Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)
Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Title XVIII of the Social Security Act, Section 1862(a)(1)(P)(10) states "Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member."

NCDs related to cosmetic, reconstructive and restorative surgery exist:
Plastic Surgery to Correct Moon Face (NCD 140.4)
Treatment of Actinic Keratosis (NCD 250.4)
Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (NCD 250.5)

Medicare does not have an NCD for breast reduction (reduction mammoplasty). National Government Services, Inc., the Part A/B Medicare Administrative Contractor with jurisdiction in the Plan's service area has an LCD for Reduction Mammaplasty (L35001) (Medicare Coverage Database search 04/22/2024).

Medicare coverage criteria are not fully established for those services not addressed in the NCDs or LCDs listed above, therefore the Plan's coverage criteria are applicable.

Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §120 – Cosmetic Surgery

Revision of or Complications as a result of Prior Cosmetic Procedure - Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

MassHealth ACO
Fallon Health follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

MassHealth has the following Guidelines related to cosmetic, reconstructive and restorative surgery:
- Guidelines for Medical Necessity Determination for Blepharoplasty, Upper Eyelid Ptosis, and Brow Ptosis Surgery
- Guidelines for Medical Necessity Determination for Breast Reconstruction
- Guidelines for Medical Necessity Determination for Excision of Excessive Skin and Subcutaneous Tissue
- Guidelines for Medical Necessity Determination for Hair Removal
- Guidelines for Medical Necessity Determination for Mastectomy for Gynecomastia
- Guidelines for Medical Necessity Determination for Reduction Mammoplasty
- Guidelines for Medical Necessity Determination for Rhinoplasty and Septoplasty

NaviCare HMO SNP, NaviCare SCO
For plan members enrolled in NaviCare, Fallon Health first follow's CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed

care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Fallon Health Clinical Coverage Criteria

Fallon Health covers reconstructive surgery when the surgery can reasonably be expected to improve or correct a physical functional impairment resulting from a congenital defect or birth abnormality, accidental injury, prior surgical procedure, or disease. The definition of reconstructive surgery is based on two distinct factors:

- Whether the surgery is primarily indicated to improve or correct a physical functional impairment (the presence or absence of a physical functional impairment is a critical point in determining eligibility for coverage); and
- What the etiology of the defect is (e.g., congenital defect or birth abnormality, accidental injury, prior surgical procedure, or disease).

Fallon Health covers restorative surgery to repair or restore appearance damaged by accidental injury. Only the initial repair is covered. If a procedure is normally done in stages, with healing periods in-between, all stages are covered. When no functional impairment is present, the etiology of the condition must be determined, and the contract language reviewed to see if this etiology is included in the definition of restorative surgery.

Cosmetic surgery, cosmetic treatments, cosmetic procedures, cosmetic medications and cosmetic supplies are not covered (even when intended to improve self-esteem or treat a mental health condition). In addition, drugs, biologicals, facility/hospital charges, laboratory and radiology charges, and charges for surgeons, assistant surgeons, anesthesiologists, and any other incidental services which are directly related to the cosmetic surgery/procedure are not covered. However, services required to treat a complication that arises as a result of a prior non-covered surgery/procedure, may be covered when medically necessary in all other respects.

The following services are covered when they are performed to improve or correct a physical functional impairment and when the surgery, procedure or treatment can reasonably be expected to improve or correct the physical functional impairment.

Eyelids

Reminder: MassHealth has Guidelines for Medical Necessity Determination for Blepharoplasty, Upper Eyelid Ptosis, and Brow Ptosis Surgery, therefore the Plan's coverage criteria are not applicable.

Upper blepharoplasty: A surgical procedure to remove redundant (excess) tissue from the upper eyelid(s):

- To correct prosthesis difficulties associated with an ophthalmic socket.
- To repair conditions causing corneal or conjunctival irritation, such as entropion, ectropion, pseudotrichiasis, or chronic dermatitis (caused by redundant eyelid tissue).
- To treat periorbital sequelae of thyroid disease, facial paralysis, or nerve palsy that is causing a physical functional impairment, such as incomplete closure of the eye, and that has not resolved after adequate medical treatment.
- To relieve painful symptoms (severe squinting secondary to uncontrollable spasms of the periorbital muscles) of primary essential idiopathic blepharospasm when other treatments have failed. To repair or restore appearance that was damaged by an accidental injury (only the initial restorative repair is covered).

Blepharoptosis repair: The term used to describe drooping of one or both eyelids. Blepharoptosis repair is a surgical procedure performed on the levator muscle (the muscle that raises the upper eyelid) to correct a visual impairment caused by drooping of the eyelids. Upper blepharoplasty is a separate and distinct procedure from blepharoptosis repair. Certain patients may have a visual field obstruction caused by the combined effects of excessive eyelid tissue and eyelid drooping.

Simultaneous upper blepharoplasty and ptosis repair may be medically necessary to provide functional improvement in these patients. When more than one procedure is requested, documentation that satisfies the criteria for each must be submitted.

Upper blepharoplasty and/or blepharoptosis repair may be medically necessary to remove excess upper eyelid tissue and/or repair a drooping eyelid causing a functional visual impairment when all the following criteria are met:

1. Documented visual complaints, such as difficulty reading, walking, or driving.
2. Visual field testing that indicates a significant loss of superior visual field. Each eye should be tested with the upper eyelid at rest and repeated with the upper eyelid skin and/or eyelid margin taped to demonstrate potential correction by the proposed procedure or procedures:
    a. Visual field obstruction by the eyelid at rest must limit the upper visual filed to within 30 degrees measured from the central fixation point.
    b. The upper visual field must improve by at least 20 degrees with the redundant eyelid tissue and/or the upper eyelid taped (such that the eyelid margin assumes the anatomic position) to demonstrate potential correction by the proposed procedure or procedures.

For upper blepharoplasty, frontal photographs demonstrating upper eyelid skin overhanging the upper eyelid margin and resting on the eyelashes. Lateral photographs may also be required to show redundant skin on the eyelashes.

Nose

Reminder: MassHealth has Guidelines for Medical Necessity Determination Rhinoplasty and Septoplasty, therefore the Plan's coverage criteria for rhinoplasty and septoplasty are not applicable.

Excision or surgical planning of rhinophyma: Rhinophyma is a condition of marked overgrowth of the sebaceous glands and fibrous tissue of the nose. The condition is thought to be associated with rosacea. Usually there is no functional physical impairment associated with rhinophyma and surgical treatment is considered ineligible for coverage on the basis of medical necessity.

1. Excision or shaving of rhinophyma may be medically necessary to treat rhinophyma that is causing a nasal obstruction that is impairing respiratory function (obstructing rhinophyma).

Rhinoplasty: A surgical procedure that is performed to change the shape and/or size of the nose or to correct a nasal defect. Rhinoplasty is most often performed for cosmetic purposes. Rhinoplasty may be medically necessary to repair a chronic, nasal obstruction that directly causes a significant and symptomatic airway compromise, secondary to a congenital defect, disease, or tumor-ablative surgery, when all of the following criteria are met:

1. Photographic documentation (if there is an external nasal deformity) along with objective documentation that substantiates the severity of symptoms.
2. There are no other identifiable causes, e.g., polyps, allergies, turbinate hypertrophy, septal defect, or chronic lung disease.
3. Documentation that a reasonable trial of appropriate physician supervised conservative treatment has failed.
4. Septoplasty and/or turbinectomy alone would not be expected to resolve the condition.

Additionally, Rhinoplasty may be covered for the below indications:

1. To repair a nasal deformity secondary to cleft lip/palate or other congenital craniofacial deformity that is causing a physical functional impairment. In the absence of an airway obstruction, cleft rhinoplasty is usually delayed until the child is about 16 years of age. (Primary nasal repair is usually done at the time of the primary cleft lip repair.)
2. To repair or restore appearance that was damaged by an accidental injury (only the initial restorative repair is covered).

Septoplasty: A surgical procedure performed to correct a deformity (or deviation) of the nasal septum. This is most often a functional surgery that repairs altered anatomy of the nasal septum and does not alter the external appearance of the nose. Septoplasty is sometimes referred to as submucous resection of the septum (SMR) or septal reconstruction. Septoplasty may be medically necessary to repair a deviated, perforated, or deformed septum that directly causes a significant and symptomatic airway compromise, recurrent nose bleeds, or recurrent sinusitis, secondary to a congenital defect, disease, trauma, or tumor-ablative surgery, when all of the following criteria are met:

1. Objective documentation that substantiates the severity of symptoms. A deviated septum is readily apparent on a CT, however, obtaining a CT scan is not necessary in a patient in whom no other pathology is suspected (e.g., concomitant sinus disease).
2. There are no other identifiable causes, e.g., polyps, allergies, turbinate hypertrophy, or chronic lung disease.
3. Documentation that a reasonable trial of appropriate physician supervised conservative treatment has failed, including the duration and dose of the actual treatments; antibiotics, nasal steroids.

Additionally, septoplasty may be covered for the below indications:

1. For the treatment of headache of septal spur origin. Septal spur headache may be diagnosed when pain is relieved temporarily by topical anesthetics are applied to the septal impaction.
2. To repair a nasal deformity secondary to cleft lip / palate or other congenital deformity that is causing a physical functional impairment.

Ears

Total external ear reconstruction: Reconstruction that is usually performed in stages. Each stage is spaced several months apart to allow for healing. Total external ear reconstruction does not include reconstruction of the external auditory canal. Total external ear reconstruction may be medically necessary:

To repair a congenital deformity (microtia) of the external ear (auricle) when criterion 1 or 2 and 3 are met:

1. Audiology evaluation and hearing testing document a significant hearing impairment and there is a likelihood that ear reconstruction will improve the hearing impairment.
2. To facilitate the use of eyeglasses or a hearing aid.
3. The patient has sufficient costal cartilage to carry out an optimal reconstruction. Generally, the costal cartilage is adequate by the time the patient is aged 9-10 years.

To repair or restore appearance that was damaged by accidental injury (only the initial restorative repair is covered), when skin quality in the auricular area secondary to burns or scarring does not prevent satisfactory results.

Reconstruction of the external auditory canal may be medically necessary:

1. To repair congenital atresia that is causing a significant hearing loss, and there is a likelihood that the procedure will improve the hearing impairment.
2. To repair a deformed (e.g., stenotic) external auditory canal caused by disease or previous surgery when a significant hearing loss is documented.
3. To repair or restore appearance that was damaged by accidental injury (only the initial restorative repair is covered).

HIV Associated Lipodystrophy Syndrome

1. For Medicare Advantage, NaviCare and PACE plan members, dermal injections for the treatment of facial lipodystrophy syndrome are covered in accordance with NCD 250.5 (Version 1, Effective 03/23/2020).

Nationally Covered Indications:
Effective for dates of service on and after March 23, 2020, dermal injections for lipodystrophy syndrome are only reasonable and necessary using dermal fillers approved by the Food and Drug (FDA) Administration for this purpose, and then only in HIV-infected Medicare beneficiaries when lipodystrophy syndrome caused by antiretroviral treatment is a significant contributor to their depression.

Nationally Non-Covered Indications:
- Dermal fillers that are not approved by the FDA for the treatment of lipodystrophy syndrome.
- Dermal fillers that are used for any indication other than lipodystrophy syndrome in HIV-infected individuals who manifest depression as a result of their antiretroviral HIV treatments.

2. For Community Care plan members, medical or drug treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome are covered in accordance with Massachusetts General Laws Chapter 176G, Section 4CC and DOI Bulletin 2016-14.

   Effective for dates of service on or after November 8, 2016, medical or drug treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome including, but not limited to reconstructive surgery, such as suction assisted lipectomy, other restorative procedures and dermal injections or fillers for reversal of facial lipodystrophy syndrome. Coverage shall be subject to a statement from the treating provider that the treatment is necessary for correcting, repairing or ameliorating the effects of HIV associated lipodystrophy syndrome.

3. For MassHealth ACO, NaviCare and Summit Eldercare PACE plan members, treatments for HIV Associated Lipodystrophy are covered in accordance with MassHealth Transmittal Letter PHY-151.

   Effective for dates of service on or after November 9, 2016, liposuction (CPT 15876-15879) and subcutaneous injection of filling material (CPT 11950-11954) are covered for the treatment of lipodystrophy associated with or secondary to HIV when the following criteria are met:
   a. The member has a diagnosis of HIV or AIDS; and
   b. The medical condition is well documented by clinical notes (photos may be required), which include a diagnosis of HIV-associated lipodystrophy syndrome, and specifically state that the treatment is necessary for correcting, repairing, or ameliorating the effects of HIV-associated lipodystrophy syndrome; and
   c. The requested procedure can reasonably be expected to treat the specific part of the body affected by HIV-associated lipodystrophy syndrome**.**

Facial (Includes the upper and lower jaw and the chin)

Rhytidectomy: A surgical procedure to remove redundant (excess) skin from the facial area. This procedure is commonly known as a facelift. Rhytidectomy may be medically necessary:
1. To restore appearance that was damaged by accidental injury (only the initial restorative repair is covered).
2. To repair a physical functional impairment secondary to a congenital defect or birth abnormality, accidental injury, prior surgical procedure, or disease (e.g., facial paralysis or nerve palsy. A functional impairment may occur when excess skin impairs eating and drinking.

Repair of cleft lip with or without nasal deformity (cheiloplasty): A surgical procedure to repair a cleft in the lip. Almost all children with a complete cleft lip and many with an incomplete cleft lip will have an associated nasal deformity. Primary cheiloplasty for cleft lip includes repair of a nasal deformity. It is unusual for the nasal deformity to be totally corrected during the primary repair and secondary rhinoplasty is quite common.

Primary repair of cleft lip with or without a nasal deformity may be medically necessary:
1. To repair a congenital cleft lip, with or without a nasal deformity, that is causing a physical functional impairment, such as difficulty eating or drinking. For safe repair under general anesthesia, it is recommended that the child be at least 10 weeks of age, weight 10 pounds or more, have an Hgb of at least 10g, and a WBC count less than 10,000/mm.

Secondary repair of cleft lip may be medically necessary:
1. To revise a congenital cleft palate repair when there has been unfavorable healing, resulting in tightness or asymmetry. Secondary repair is accomplished by recreating the defect and closing it with a more satisfactory alignment.

Palatoplasty for cleft palate: A surgical procedure to repair a cleft in the soft and or hard palate. Primary palatoplasty is the initial cleft palate repair which is usually completed during the first year of life. Primary palatoplasty may be performed with or without soft tissue closure of alveolar ridge, and with or without bone graft (see Maxillary alveolar cleft repair with bone graft below).

Sequelae of cleft lip and/or palate:
- Nasolabial, oromaxillary, and/or oronasal fistula(s)
- Maxillary alveolar ridge cleft

Primary palatoplasty may be medically necessary:
1. To repair a congenital cleft palate that is causing a physical functional impairment. A cleft palate may impair feeding, speech impairments (hypernasal speech) and dental development.

Secondary palatoplasty may be medically necessary:
1. To repair a congenital cleft palate repair that is causing a physical functional impairment, such as velopharyngeal incompetence (hypernasal speech).

Revision palatoplasty with pharyngeal flap repair should be done when it is absolutely clear that palate function is inadequate, and speech has not improved with speech therapy. This flap can have a profound effect on breathing. Airway compromise in patients who undergo pharyngeal flap palatoplasty can be a potentially fatal complication.

Maxillary alveolar cleft repair with bone graft: Is a cleft of the dental ridge (gum line) of the upper jaw (maxilla) that commonly occurs in children with facial clefts. Maxillary alveolar cleft ridge repair may be medically necessary:
1. To repair a congenital maxillary alveolar cleft that is causing a physical functional impairment, such as, when the cleft impairs normal dental development.

Repair of nasolabial, oromaxillary, and/or oronasal fistula(s): Some children with cleft palates, with or without cleft lips will be left with a fistula after the primary repair. In some cases, the fistula is left intentionally, in other cases it has developed because of poor healing. Fistulas may also be caused by infection, trauma or as a complication of removing a tooth. Repair of nasolabial, oromaxillary, and/or oronasal fistula(s) may be medically necessary:
1. To repair a fistula that is causing a physical functional impairment, such as difficulty eating or drinking or when the fistula impairs speech

Mentoplasty: Refers to plastic surgery procedures for the chin. Mentoplasty may be medically necessary:

1. To repair or restore appearance that was damaged by accidental injury (only the initial restorative repair is covered).
2. To improve or correct a physical functional impairment (the ability to speak or chew normally) resulting from a congenital defect or birth abnormality, accidental injury, prior surgical procedure or disease. Dental history and x-rays of the head and jaw are necessary in order to determine whether the impairment can be corrected by a chin implant, augmentation or reduction.
3. In conjunction with a covered orthognathic surgery to correct deformities of the jaw.

Chest

Reminder: National Government Service, Inc. the Part A/B Medicare Administrative Contractor with jurisdiction in the Plan's service area has an LCD for Reduction Mammaplasty (L35001), therefore the Plan's coverage criteria are not applicable.

Reminder: MassHealth has Guidelines for Medical Necessity Determination for Mastectomy for Gynecomastia and Guidelines for Medical Necessity Determination for Reduction Mammoplasty, therefore the Plan's coverage criteria are not applicable.

In accordance with the Women's Health & Cancer Rights Act of 1998, breast reconstruction following mastectomy is covered, as are procedures of the contralateral breast to achieve symmetry. Refer to Post-Mastectomy Surgery and Services policy for coverage of services following mastectomy. Additionally Fallon Health will consider coverage for reconstruction post-lumpectomy. All other breast procedures must meet the below criteria.

There are three general categories of mammoplasty (i.e., plastic surgery performed on the breasts):

- Augmentation mammoplasty: Augmentation mammoplasty is a surgical procedure in which the breasts are augmented or enlarged, usually with implants placed under or over chest muscle. (Note: coverage is limited for this procedure only for post-mastectomy or lumpectomy.)
- Reduction mammoplasty: Reduction mammoplasty is a surgical procedure in which excess breast tissue is excised.
- Breast reconstruction: Breast reconstruction surgery may be performed when a breast has been disfigured due to trauma or following mastectomy. This procedure recreates a breast with the desired appearance.

Reduction mammoplasty: Reduction mammoplasty may be medically necessary to relieve a physical functional impairment caused by hypertrophic breasts when all of the following criteria are met:
Medical records from the primary care physician and other providers (for example, dermatologist, orthopedic surgeon, physical therapist, etc.) who have diagnosed or treated the symptoms prompting this request are also required.

1. The patient is 16 years of age or older and has reached physical maturity.
2. There is a reasonable likelihood that the member's symptoms are primarily due to macromastia, and reduction mammoplasty is likely to result in improvement of symptoms.
3. The patient has significant symptoms that have interfered with activities of daily living, despite physician supervised conservative management, for at least six months, including at least one of the following:
    a. Back and/or shoulder pain unrelieved by physician supervised conservative measures including analgesia (e.g., NSAIDs, compresses, etc.), supportive garments, physical therapy, and correction of obesity (defined as BMI > 35).

b. Significant, symptomatic arthritic changes (signs and symptoms of ulnar paresthesias, cervicalgia, torticollis or kyphosis) in the cervical or upper thoracic spine.
c. Intertriginous maceration or infection of the inframammary skin, refractory to dermatologic measures.
d. Shoulder grooving with skin irritation (areas of excoriation and breakdown) by appropriate supporting garment.

4. To be considered non-cosmetic it is expected that at least a minimal amount of breast tissue will be removed. There are wide variations in the range of height, weight, and breast size that will cause symptoms and the amount of tissue that must be removed in order to relieve symptoms will vary. The following are Fallon Health medical criteria based on body surface area that address the anticipated amount of breast tissue to be excised:

Minimum Weight of Breast Tissue Removed, per Breast , as function of Body Surface Area – Schnur Sliding Scale	
Body Surface Area	Minimum weight of tissue to be removed per breast (grams)
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978
2.30 or greater	>/= 1000

Breast reconstruction may be medically necessary:

1. To repair or restore appearance of a breast that was damaged by accidental injury (only the initial restorative repair is covered).
2. To repair or restore appearance of one or both breasts following a covered prophylactic mastectomy.

Removal of breast implants: Implants do not last a lifetime and will likely need to be removed either because of rupture, capsular contracture, or other complications. There are two main types of breast implants Saline-filled breast implants and Silicone gel-filled breast implants. Both types of breast implants have a silicone rubber protective shell (capsule). It is not medically necessary to remove a ruptured saline-filled breast implant, in the absence of other signs or symptoms (e.g., significant capsular contracture or persistent infection). Removal of either a silicone gel-filled breast implant or a saline-filled breast implant may be medically necessary:

1. To facilitate the treatment of breast cancer.
2. For the treatment of persistent or recurrent local or systemic infection, secondary to a breast implant, that is refractory to medical management including antibiotics.

3. For the treatment of Baker Grade IV Capsular Contracture that is causing pain, persistent infection refractory to medical management, or is interfering with preventive breast cancer screening.
   The Baker grading is as follows:
   - Grade I the breast is normally soft and looks natural
   - Grade II the breast is a little firm but looks normal
   - Grade III the breast is firm and looks abnormal
   - Grade IV the breast is hard, painful, and looks abnormal
4. Removal of a ruptured silicone gel-filled breast implant (intracapsular or extracapsular rupture) that has been confirmed with MRI or other conclusive imaging study is medically necessary.

When criteria for removal of a breast implant are met unilaterally, removal of the implant in the contralateral breast is covered as long as both implants are removed at the same time.

Even when removal of breast implants meets medical necessity criteria, reinsertion of replacement breast implants is considered cosmetic and is not covered.

Mastectomy for gynecomastia: The male breast contains both glandular and fatty tissue. Gynecomastia results from proliferation of glandular tissue. The proliferation of only fatty tissue is known as pseudogynecomastia. Gynecomastia occurs most frequently during times of male hormonal changes, resulting from the effect of an altered estrogen/androgen balance, in favor of estrogen, on breast tissue. The majority of patients with gynecomastia require no treatment other than removal of the precipitating cause. Psuedogynecomastia is common in obese men and is differentiated from true gynecomastia by the presence of increased subareolar fat without enlargement of the breast glandular component:

1. The patient is 17 years of age or older, has been diagnosed with gynecomastia on physical examination, and the gynecomastia and its associated signs and symptoms have been followed and documented by a physician over at least a 12-month period, AND
2. The patient has had a consult with an endocrinologist to identify and treat or correct any underlying causes, AND
3. Despite treatment or correction of any underlying causes, gynecomastia and signs/symptoms have persisted for greater than 12 months with no evidence of reversal; AND
4. Patient has persistent subareolar pain documented in the medical record, which is refractory to analgesics and has a clinically significant impact upon activities of daily living, AND
5. Preoperative photographs are provided.

Mastopexy: Also known as a breast lift surgery refers to a surgical procedure designed to lessen the degree of breast ptosis (sagging). Mastopexy is not a covered benefit (except following a mastectomy; refer to Post-Mastectomy Surgery and Services policy for additional information).

Prophylactic mastectomy: The preventive surgical removal of one or both breasts to prevent or reduce the risk of breast cancer. There are two surgical procedures for prophylactic mastectomy: total (simple) mastectomy or subcutaneous mastectomy. Neither procedure completely removes all breast tissue nor is the risk for breast cancer is completely eliminated. Prophylactic mastectomy may be medically necessary:

1. To prevent or reduce the risk of breast cancer in a female patient with a known BRCA1 or BRCA2 mutation confirmed by genetic testing.
2. To prevent or reduce the risk of breast cancer in a female patient who has a first or second-degree relative with a known BRCA1 or BRCA2 mutation confirmed by genetic testing.
3. To prevent or reduce the risk of recurrent breast cancer in a male or female patient with a personal history of breast cancer.

Congenital chest wall deformities: Deformities that arise from abnormal development of the sternum, the costal cartilages, and the ribs. Such defects include pectus excavatum, pectus carinatum, and Poland syndrome (absence of the breast and the underlying pectoralis muscle and ribs). Of these, pectus excavatum is by far the most common, accounting for more than 90% of all congenital chest wall procedures.

1. Surgical repair of pectus excavatum may be medically necessary when the Haller Index (transverse chest to narrowest anterioposterior diameter) is 3.25 or higher.
2. Surgical repair of pectus carinatum may be medically necessary when a rigid or restrictive chest wall results in less than optimal respiration, such as incomplete expiration, or exertional dyspnea. Pulmonary function testing may be useful to determine the impact of the deformity on the performance of the heart and lungs (affected individuals may not be aware of the gradual decrease in exercise tolerance that occurs over time).
3. Surgical repair of Poland syndrome may be considered medically necessary to repair a physical functional impairment secondary to a chest wall deformity. The most frequent indication for reconstructive surgery is severe chest asymmetry in which the chest viscera are exposed and susceptible to trauma. Costal aplasia or hypoplasia without physical functional impairment (such as respiratory compromise or exercise intolerance) is not an indication for repair.

Surgical repair of inverted nipple: An inverted nipple is defined as a nipple located on a plane lower than the areola. Nipple inversion is categorized according to severity, with Grade III being the most severe. Grades I and II rarely impair breast feeding. Grade III may impair breast feeding; however, surgical repair does not consistently restore functionality, i.e., the ability to breast feed. Surgical repair of inverted nipple may be medically necessary:

1. To repair an inverted nipple that is causing a physical functional impairment, i.e., the inability to breast feed, and the procedure can be reasonably expected to restore functionality. It is not possible to know whether or not an inverted nipple will impair breast feeding until breast feeding has been attempted.

Abdomen

Reminder: MassHealth has Guidelines for Medical Necessity Determination for Excision of Excessive Skin and Subcutaneous Tissue, therefore the Plan's coverage criteria for panniculectomy are not applicable.

Panniculectomy: The surgical excision of redundant (excess) hanging abdominal skin and fat (panniculus) but does not include muscle plication or neoumbilicoplasty as in an abdominoplasty. Panniculectomy is not covered when performed as an adjunct to other medically necessary procedures such as, hysterectomy or ventral/incisional hernia repair unless the criteria for panniculectomy are independently met. Panniculectomy may be medically necessary:

Medical records from the primary care physician and other providers (for example, dermatologist, orthopedic surgeon, physical therapist, etc.) who have diagnosed or treated the symptoms prompting this request are also required.

1. The panniculus hangs below the level of the pubis (photographic documentation is required), AND
2. The panniculus is the result of weight loss, AND
3. Weight loss of at least 75 pounds has been sustained for at least six months (AND if weight loss is the result of bariatric surgery, panniculectomy is not covered until at least 18 months after bariatric surgery), AND
4. It is documented in the patient's medical record that the panniculus directly impairs physical function, i.e., the panniculus: Interferes with ambulation, urination or other activities of daily living, or

5. Causes recurring persistent intertriginous rashes, ulcerations, and/or infections that develop in the abdominopelvic fold (panniculitis) and that are refractory to good personal hygiene and documented optimal medical management including local and systemic medications.

Panniculectomy and abdominoplasty are often performed together to achieve the best cosmetic result. (Abdominoplasty is an add-on procedure that cannot be billed alone). Abdominoplasty is not a covered benefit.

Diastasis recti abdominis repair: The separation of the left and right side of the rectus abdominis muscle. Diastasis recti abdominis occurs primarily in pregnant women and newborns, but may also occur in patients with chronic obstructive pulmonary disease, following abdominal surgery, or with obesity. Diastasis recti abdominis repair may be medically necessary:
1. If a hernia develops and becomes trapped in the space between the muscles. The recti abdominis muscle may be repaired at the time of the hernia repair to prevent recurrence.

Skin

Tattooing: The introduction of insoluble pigments to correct color defects of the skin. Tattooing may be medically necessary:
1. To give the nipple-areola complex a more natural appearance following breast reconstruction surgery.
2. To repair or restore appearance of skin (scar or burn camouflage) that has been damaged by accidental injury (only the initial restorative repair is covered).

Tattooing is not separately reimbursable in conjunction with radiation therapy.

Tattooing is considered cosmetic (i.e., not medically necessary) for the treatment of vitiligo because it does not treat the underlying condition or result in improved protection against skin cancer.

Tattoo removal: The removal of tattoos is attempted with laser treatments, abrasion, or dermabrasion. Multiple treatments may be needed and results will vary depending on the size of the tattoo and the color and quality of the ink used. Some tattoos cannot be completely removed and some treatments may cause scarring. Removal of a decorative tattoo is not covered. Tattoo removal may be medically necessary:
1. To remove a positional tattoo placed to facilitate radiation therapy.

Scar revision: The timing of scar revision is variable. Most scars will show some improvement for up to 1 to 3 years without revision. A scar that is uneven, shows a marked step-off, or is obviously poorly positioned may be revised as early as 2 months after the original closure. If it is possible to tell early that a scar will not improve with maturation, there is not a compelling reason to make the patient wait. In fact, early revision with realignment of the scar may allow it to mature more rapidly.
Several techniques can minimize a scar however no scar can ever be completely removed. Fallon Health covers the following scar revision techniques:
- Tissue transfer, i.e., flaps and grafts
- Scar reexcision
- Scar rearrangement (i.e., Z-plasty, W-plasty)
- Abrasion or dermabrasion
- Pulsed dye laser
- Intralesional corticosteroid injections

Scar revision may be medically necessary:
1. When the scar is the result of accidental injury (the injury must have taken place on or after the plan member's effective date with Fallon Health), or

2. When the scar causes a physical functional impairment, i.e., the scar interferes with the movement of a joint, or when the scar is associated with symptoms of intense pain, burning, or itching that cannot be effectively treated with local and or systemic medication, such as analgesics, corticosteroids or antibiotics, or
3. When the scar has a history of intermittent breakdown.

Excision of redundant (excess) skin and subcutaneous tissue of the thighs, hips, buttocks, arms, or other anatomical areas: (See Panniculectomy for excision of redundant skin and subcutaneous tissue of the abdomen) Removal of redundant skin, for any reason, including massive weight loss due to bariatric surgery, when there is not a functional physical impairment, is considered cosmetic. Excess skin is an expected outcome after weight loss. Excision of redundant (excess) skin and subcutaneous tissue of the thighs, hips, buttocks, arms, or other anatomical areas, may be medically necessary:

1. In cases where the redundant skin is the result of weight loss of greater than 75 pounds, the weight loss has been sustained for at least six months (AND if weight loss is the result of bariatric surgery, excision of redundant skin is not covered until at least 18 months after bariatric surgery), AND
2. It is documented in the patient's medical record that the redundant skin directly causes a physical functional impairment; i.e., the redundant skin:
    a. Interferes with mobility, urination, or other activities of daily living, or
    b. Causes recurring persistent intertriginous rashes, ulcerations, and/or infections that are refractory to good personal hygiene and documented optimal medical management including local and systemic medications, AND
3. The redundant skin is documented in photographs.

Subcutaneous injection of filling material: Injections of filling material, such as bovine collagen, are used to raise, or fill in, sunken scars. The results of collagen injections are immediate but temporary. The scars will eventually have to be re-filled as the body slowly absorbs the collagen. Injection of filling materials is not covered for the treatment of acne or chicken pox scars, facial wrinkles or other cosmetic purposes. Subcutaneous injection of filling material may be medically necessary

1. To repair a distensible scar, when the scar itself is the result of an accidental injury. A distensible scar is one that elevates to the surface when tension is placed on either side. (This test will allow the clinician to determine whether the particular scar will likely respond to filling material. Placing filling material in a fibrotic or fixed scar will elevate the surrounding skin, producing a donut effect and making the scar appear worse.)

Abrasion: Is typically performed to improve the appearance of one or more small, isolated scars. Techniques vary and may include a high-speed rotary abrasive instrument, fine-grit sandpaper, laser, or a curette. Abrasion may be medically necessary:

1. To improve the appearance of a small scar that is the result of an accidental injury (restorative).
2. To remove a positional tattoo placed to facilitate radiation therapy

Dermabrasion: Is typically performed to improve the appearance of a scar or large areas of scarring. Techniques vary and may include a high-speed rotary abrasive instrument, fine-grit sandpaper, CO2 or YAG laser, or a curette. Dermabrasion may be performed following other scar revision techniques, such as, running Z-plasty, or W-plasty, to better blend the new scar with the surrounding skin. Dermabrasion for removal of acne, or acne or chicken pox scars is considered cosmetic and not medically necessary.

Dermabrasion may be medically necessary:

1. To improve the appearance of a large scar or a large area of scarring that is the result of an accidental injury (restorative).

2. To remove a positional tattoo placed to facilitate radiation therapy.

Dermabrasion may be considered medically necessary to remove large numbers of actinic keratoses (more than 10), when it is impractical to treat each lesion separately, and where there is a record of conventional methods, including cryosurgery, and topical medications, such as 5-fluorouracil, having been proved unsuccessful (unless contraindicated). However, destruction of actinic keratoses has its own CPT codes (17000-17004).

Please see Fallon Health's separate policy for Varicose Vein Treatment for detailed coverage of these procedures.

Hair

Reminder: MassHealth has Guidelines for Medical Necessity Determination for Hair Removal, therefore the Plan's coverage criteria are not applicable.

Hair transplant: Hair may be transplanted from the scalp or other hair-containing tissue to an area devoid of hair by either strip graft (CPT codes 15220 and 15221) or punch graft (CPT codes 15775 and 15776). Hair transplant performed to correct male pattern baldness, age-related hair thinning, baldness (alopecia) due to disease, previous therapy, or congenital scalp disorders is cosmetic and not covered. Hair transplant may be medically necessary:

1. To improve the appearance of a scar in the scalp that is the result of an accidental injury (restorative).

Exclusions

- Cosmetic surgery, cosmetic treatments, cosmetic procedures, cosmetic medications and cosmetic supplies, including, but not limited to: otoplasty for protruding ears; ear piercing; abdominoplasty; chemical peel (dermal and epidermal); microdermabrasion; and hair removal.
- Services related to cosmetic surgery, cosmetic treatments, and cosmetic procedures are not covered. This includes but is not limited to physician charges, hospital charges, charges for anesthesia, drugs, etc.
- Care of the teeth and supporting structures, including reconstructive, major restorative or cosmetic dental services, such as dental implants (also known as osseointegrated or titanium implants), dentures, crowns, and orthodontics. Care of the teeth and supporting structures is not covered, even when part of a covered medical procedure, such as a cleft lip/palate repair. Similarly, medical or surgical procedures in preparation for a dental procedure are also not covered (for example, a bone graft to prepare for a dental implant). (Some plan members may have a dental rider which provides coverage for certain preventive and minor restorative dental services, such as periodic cleanings and fillings. The services that are covered are listed in the Dental Addendum "Covered Dental Services Copayments.")
- Surgery, treatments, procedures, medications, and supplies to prevent snoring.
- Removal of intact breast implants for suspected autoimmune or connective tissue disease or for breast cancer prevention because these indications are considered experimental and investigational.
- Removal of an intact breast implant that has shifted. Implant shifting in the absence of refractory infection or Stage IV capsular contracture is not medically necessary.
- Liposuction, also known as suction lipectomy or suction assisted lipectomy, is the surgical excision of subcutaneous fatty tissue. Liposuction (CPT codes 15876-15879) is not covered, except for the treatment of lipodystrophy syndrome in accordance with regulatory requirements (MGL Chapter 176G, Section 4CC and MassHealth Transmittal Letter PHY-151).. However, liposuction is an integral part of certain covered services, such as the surgical removal of excessive skin (CPT codes 15830-15839) but is not separately reimbursed.

- Treatments for acne scarring including, but not limited to subcutaneous injections to raise acne scars, chemical exfoliation, and dermabrasion.
- The following treatments for active acne are not covered: acne surgery, cryotherapy for acne (CPT code 17340), chemical exfoliation for acne (CPT code 17360), and laser and light-based therapies, including but not limited, to blue light therapy, pulsed light, and diode laser treatment.
- Otoplasty to correct protruding ears, with or without size reduction (CPT code 69300).
- Ear piercing is cosmetic surgery and not medically necessary.
- Chemical peels (dermal and epidermal) are not covered. Note: Dermal peel may be used to remove large numbers of actinic keratoses (more than 10), when it is impractical to treat each lesion separately, and where there is a record of conventional methods, including cryosurgery, and topical medications, such as 5-fluorouracil, having been proved unsuccessful (unless contraindicated). However, destruction of actinic keratoses has its own set of CPT codes (17000-17004).
- Hair removal, by any method, temporary or permanent, including, but not limited to, electrolysis, waxing, or laser hair removal, is cosmetic and not covered, even if the excessive hair is caused by a medical condition.

Summary of Evidence

Panniculectomy and Abdominoplasty

The American Society of Plastic Surgeons (ASPS) Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients (June 2017) focuses on the surgical treatment of the excess skin and fat that occurs in obese patients or that remains following massive weight loss. According to the ASPS website, an evidence-based guideline for panniculectomy and abdominoplasty is in progress for 2024.

When panniculectomy is performed solely to enhance a patient's appearance in the absence of any signs or symptoms of functional abnormalities, the procedure is cosmetic in nature and not a compensable procedure unless specified in the plan member’s Evidence of Coverage.

Panniculectomy could be considered as a functional correction in patients who are of appropriate height and weight, and have a history of problems including panniculitis or chronic back pain that have persisted despite an adequate trial of non-surgical management, or have a functional impairment in activities of daily living/ work, etc.

Panniculectomy involves the removal of hanging excess skin/fat in a transverse or vertical wedge but does not include muscle plication, neoumbilicoplasty or flap elevation. A cosmetic abdominoplasty is sometimes performed at the time of a functional panniculectomy or delayed pending completion of weight reduction. There are similarities between a panniculectomy and abdominoplasty as both procedures remove varying amounts of abdominal wall skin and fat. Abdominoplasty, also referred to as “tummy tuck” includes fascial plication of the rectus muscle diastasis and a neoumbilicoplasty.

There are very few alternative treatment options for those patients who are not surgical candidates. The excess skin and folds are virtually impossible to correct by diet, weight loss, or exercise. Deformities associated with massive weight loss vary greatly depending on the patients’ body type, their fat deposition pattern, and the amount of weight gained or lost. These deformities can lead to patient dissatisfaction with appearance, inability to exercise, impaired ambulation, chronic back, neck and shoulder pain, difficulty with hygiene and symptoms such as uncontrolled intertrigo, infections, and skin necrosis.

The surgical removal of redundant skin is ideally performed after the patient maintains a stable weight for two to six months. For post bariatric surgery patients, this often occurs 12-18 months after surgery or at the 25 kg/mg^2 to 30 kg/mg^2 weight range. Sometimes procedures are staged. An initial functional panniculectomy with limited tissue undermining and/or reduction

mammaplasty may be necessary to increase the patient's comfort and facilitate the ease of exercise and further weight loss. Once the patient approaches his/her ideal body weight more refined body contouring surgery may be performed to address aesthetic issues.

Excess skin and fat affect the entire trunk region; however, the area that is usually emphasized is the anterior abdomen. The severity of abdominal deformities is graded as follows:
1. Grade 1: panniculus covers hairline and mons pubis but not the genitals
2. Grade 2: panniculus covers genitals and upper thigh crease
3. Grade 3: panniculus covers upper thigh
4. Grade 4: panniculus covers mid-thigh
5. Grade 5: panniculus covers knees and below

There is a strong relationship between increased BMI and surgical complication across the surgical spectrum.

In rare circumstances surgeons may perform a hernia repair in conjunction with a panniculectomy or abdominoplasty. A true hernia repair involves opening fascia and/or dissection of a hernia sac with return of intraperitoneal contents back to the peritoneal cavity. A true hernia repair should not be confused with diastasis recti repair, which is part of an abdominoplasty.

Analysis of Evidence (Rationale for Determination)

The American Society of Plastic Surgeons supports that certain procedures may be considered as reconstructive in nature and medically reasonable and necessary in those situations where functionality needs to be restored and any deformities need to be corrected.

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage or reimbursement.

In the case where a functional panniculectomy is combined with plication of the rectus abdominis muscle and/or translocation of the umbilicus, this may be completed as a single stage procedure but the plication of the rectus abdominis muscle and/or translocation of umbilicus should be considered purely cosmetic and separately billed to the patient.

CPT Code	Description
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or

	less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (eg tattoo removal)
15786	Abrasion, single lesion (eg keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid;
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid;
15823	Blepharoplasty, upper eyelid; with excessive skin weighing down lid
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg abdominoplasty) includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17000	Destruction (eg laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first

	lesion
17003	Destruction (eg laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)
17004	Destruction (eg laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); 15 or more lesions
17006	Destruction of cutaneous vascular proliferative lesions (eg laser technique); less than 10 sq cm
17007	Destruction of cutaneous vascular proliferative lesions (eg laser technique); 10.0 to 50.0 sq cm
17008	Destruction of cutaneous vascular proliferative lesions (eg laser technique); over 50.0 sq cm
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions
19300	Mastectomy for gynecomastia
19316	Mastopexy
19318	Breast reduction
19325	Breast augmentation with implant
19328	Removal of intact breast implant
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)
19355	Correction of inverted nipples
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
21740	Reconstructive repair of pectus excavatum or carinatum; open
21742	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), without thoracoscopy
21743	Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach (Nuss procedure), with thoracoscopy
30120	Excision or surgical planning of skin or nose for rhinophyma
30220	Insertion, nasal septal prosthesis (button)
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair

30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip septum, osteotomies
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)
30630	Repair nasal septal perforations
67830	Correction of trichiasis; incision of lid margin
67835	Correction of trichiasis; incision of lid margin, with free mucous membrane graft
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
67909	Reduction of overcorrection of ptosis
67911	Correction of lid retraction
67912	Correction of lagophthalmos, with implantation of upper eyelid lid load (eg, gold weight)
67914	Repair of ectropion; suture
67916	Repair of ectropion; excision tarsal wedge
67917	Repair of ectropion; extensive (eg, tarsal strip operations)
67973	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, 1 stage or first stage
67974	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, upper, 1 stage or first stage
67975	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; second stage
69300	Otoplasty, protruding ear, with or without size reduction

HCPCS Code	Description
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)
Q2026	Injection, Radiesse, 0.1 ml
Q2027	Injection, sculptra, 0.5 mg

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to include MassHealth Guidelines for Medical Necessity Determination; added Summary of Evidence and Analysis of Evidence (Rationale for Determination); added Coding section; updated References).

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.