Clinical Policy: Cosmetic Surgery

Reference Number: MI.CP.MP.515
Last Review Date: 09/2022

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

All cosmetic surgery requires prior authorization and review by a Meridian Health Plan Medical Director

Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, involution defects, or disease. It is generally performed to improve function but may also be done to approximate a normal appearance.

When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions of this policy.

Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Therapies and procedures intended to change or restore appearance for cosmetic purposes are not a covered benefit. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures.

Coverage is not provided for elective cosmetic procedures regardless of the underlying causes of the condition and even if it is expected that the proposed cosmetic procedure may be psychologically beneficial to the member.

Cosmetic surgery or expenses incurred in connection with such surgery are not covered under the Medicaid program, 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.

Policy/Criteria

I. It is the policy of Meridian Health that cosmetic surgery is **medically necessary** for **any one** of the following indications:
   A. **Cosmetic Surgery** will be evaluated to determine medical necessity if **any** of the following exist:
      i. The condition interferes with employment.
      ii. It causes significant disability or psychological trauma (as documented by psychiatrist).

iii. It is a component of a reconstructive surgical procedure performed to correct a congenital deformity or trauma.
iv. It contributes to a major health problem.
v. It causes a functional disturbance of an organ system.

The physician must document the specific reasons any of the above criteria are met in the PA request and provide photographs to support the medical documentation.

B. **Hypertrophic Scars/ Keloids/ Scar Revision:** The following procedures will be considered for medical necessity on an individual basis when **either** of the following are met:
   i. Documentation that the scar causes chronic pain or a functional limitation requiring medication or limits activities of daily living and is refractory to non-operative measurements including injection therapies.
   ii. Revision of disfiguring and extensive scars resulting from neoplastic surgery.
C. **Excision of excessive skin and subcutaneous tissue** will be considered for medical necessity when **either** of the following are met:
   i. These procedures are performed in conjunction with another surgery where the excessive tissue would affect the healing of the surgical incision. Photograph(s) must be provided as well as a description of planned surgical incision that would heal improperly unless excision of excessive skin and subcutaneous tissue is performed
   ii. Skin tag removal when located in an area of friction with documentation of repeated irritation and bleeding.
   iii. Other additional areas will be considered on a case-by-case basis.
D. **Mastectomy related benefits for members with a history of breast cancer** will be considered for medical necessity when **any** of the following are met:
   i. Reconstruction of the breast on which the mastectomy was performed
   ii. Surgery and reconstruction of the other breast to produce a symmetrical appearance
   iii. Prosthesis (breast implants)
   iv. Treatment of physical complications at all stages of the mastectomy, including lymphedema (swelling caused by an accumulation of lymph fluid in the arm).

   **** Mastectomy related benefits as outlined above may be approved at the nursing level if criteria are met. ****

E. It is the policy of Meridian Health affiliated with Centene Corporation® that removal or biopsy of suspicious skin lesions is **medically necessary** for the following indications:
   Requests for biopsy or removal of suspicious skin lesions can be approved by the nursing staff if any of the following is present.
   i. Lesion size is greater than 5 mm
   ii. Lesion is changing

a. Rapid growth, color change

iii. Lesion is bleeding
iv. Lesion has an ulceration
v. Lesion has an irregular border
vi. Lesion is causing pain

F. Requests for biopsy or removal of suspicious lesions that do not have one of the above characteristics will be referred to the medical director.

II. Limitations and Exclusions

A. Meridian does not consider therapies and procedures that are intended to change or restore one's appearance for cosmetic purposes a covered benefit. Coverage is not provided for cosmetic procedures regardless of the underlying cause of the condition; however, it can be approved for psychological trauma if documented by a psychiatrist. While this policy statement addresses many common procedures, it does not address all procedures that might be considered cosmetic surgery and excluded from coverage. Procedures that are cosmetic and not medically necessary are not a benefit of the health plan. Cosmetic reconstructive or plastic surgery performed in connection with certain conditions is specifically excluded. The following procedures are considered cosmetic in nature, therefore, **not a covered benefit:**

i. Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.
ii. Cosmetic reconstructive or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.
iii. Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.
iv. Cosmetic, reconstructive, or plastic surgery procedures which are justified primarily on the basis of a psychological or psychiatric need.
v. Face lifts and other procedures related to the aging process.
vi. Reduction mammoplasties, unless medical necessity is met (CP.MP.51 Reduction Mammoplasty and Gynecomastia Surgery).
vii. Panniculectomy and body sculpture procedures, unless there is medical documentation of chronic infection or other complication. MI.CP.MP.510)
viii. Chemical peeling for facial wrinkles
ix. Dermabrasion of the face
x. Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.9/
xi. Removal of tattoos
xii. Hair transplants
xiii. Electrolysis or laser hair removal

B. When it is determined that a cosmetic reconstructive or plastic surgery procedure does not qualify for Medicaid coverage, all related services and supplies, including institutional costs, are also excluded.
C. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a non-covered incident of treatment, but only when the subsequent complications represent a separate medical condition, such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions.
D. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial non-covered care. An example of complications similar to the initial care are repair of facial scarring resulting from Dermabrasion for acne.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
N/A	

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		12/17/10
Annual Review	9/2020	9/2020
Annual Review • Updates made to references • Added terminology to section C ‘Excessive Skin’: Other additional areas will be considered on a case-by-case basis.	08/27/2021	09/28/2021

Reviews, Revisions, and Approvals	Revision Date	Approval Date
• Formatting updates to align with Centene corporate policy template.		
Added review of suspicious skin lesions		12/10/21
Annual Review with no changes	7/2022	9/2022

References

1. The Women's Health and Cancer Rights Act (WHCRA). October 21, 1998 : https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet
2. Michigan Department of Community Health. Medicaid Provider Manual. Noncovered services, Section 8.3 pg. 23 (Version Date: July 1,2022 : https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a

discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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